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BOSTON
JAN 11 1932

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PUBLIC HEALTH NUMBER

A Reminder—All membership dues in the Ohio State Medical Association for 1932 are due on or before January 1. If you have delayed in your payment, you should get in touch promptly with the Secretary-Treasurer of your County Society or Academy of Medicine.

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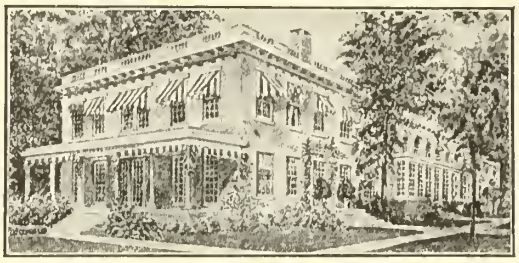
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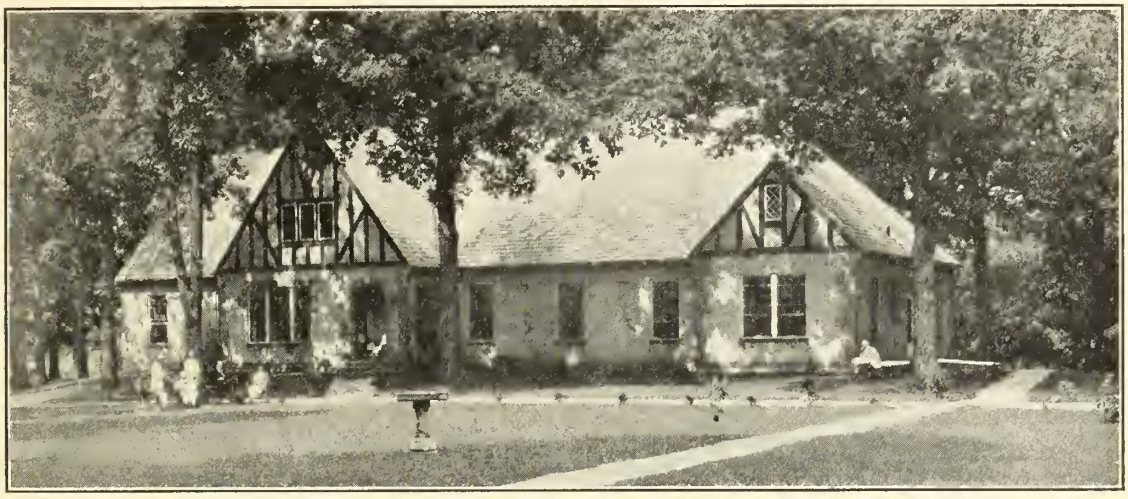
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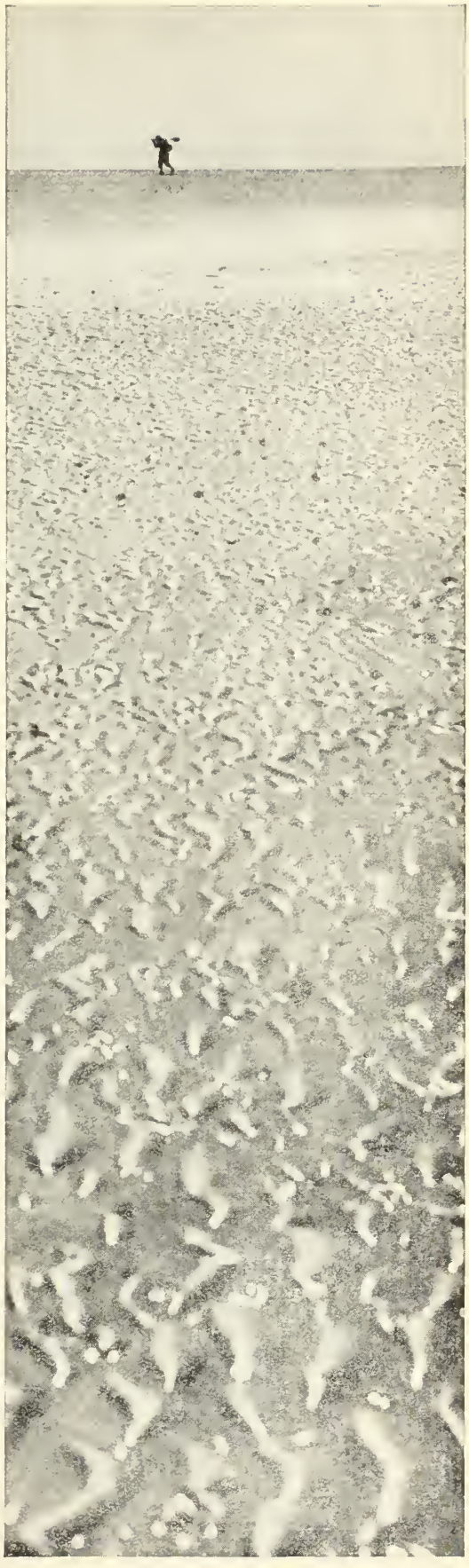
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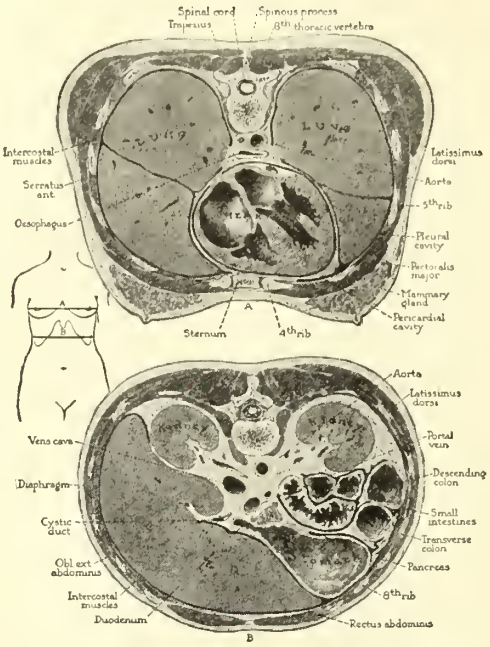
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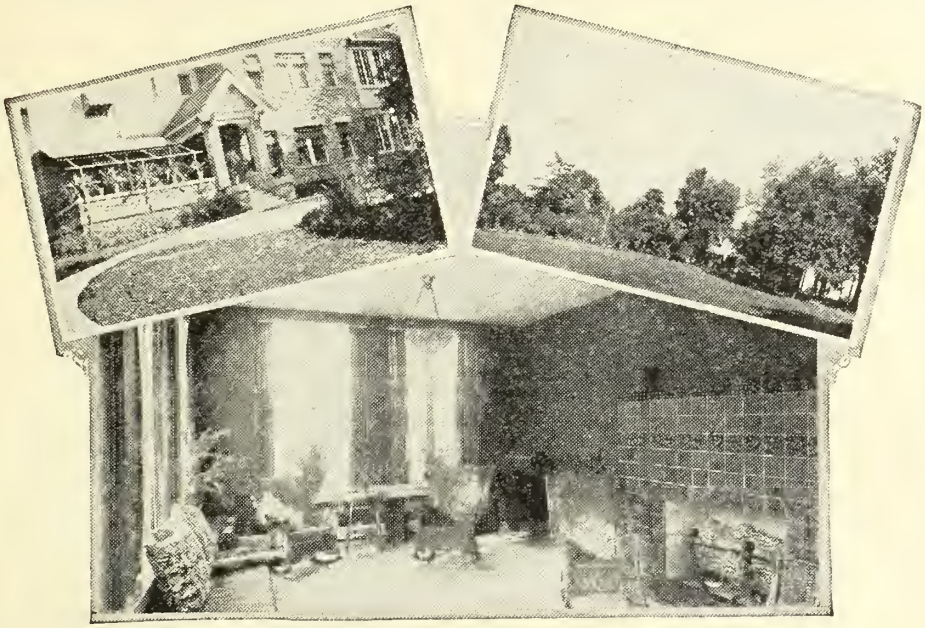
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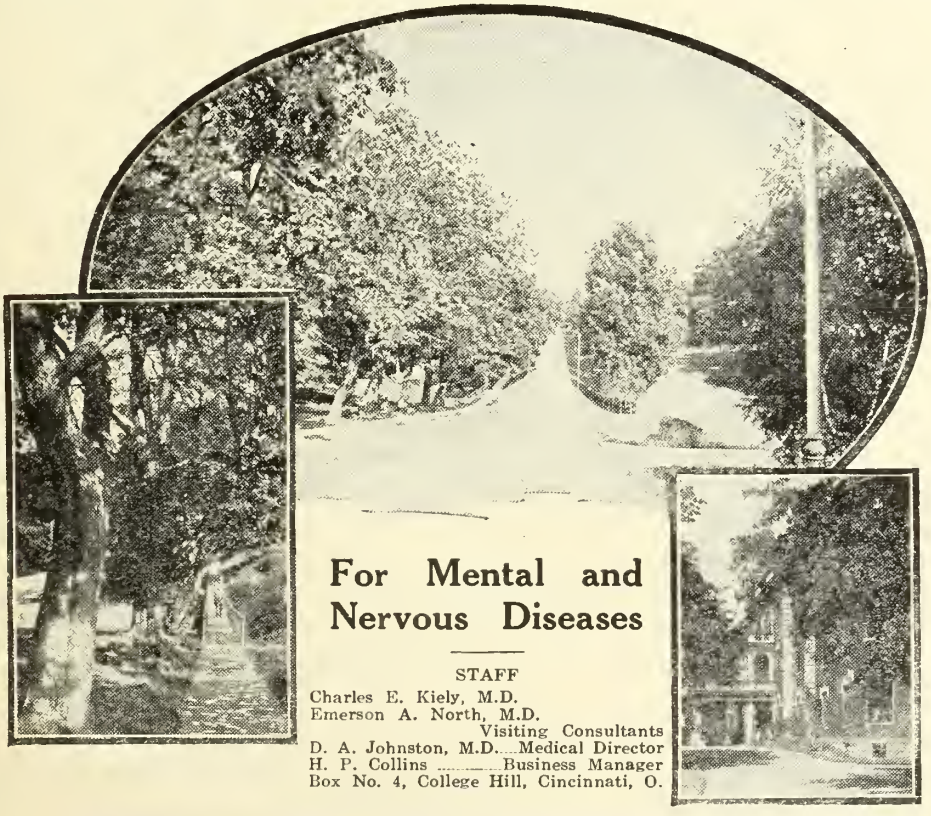
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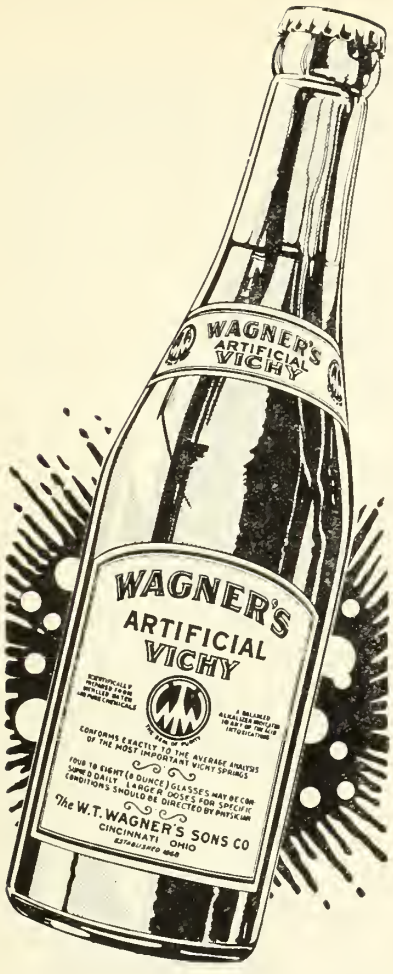
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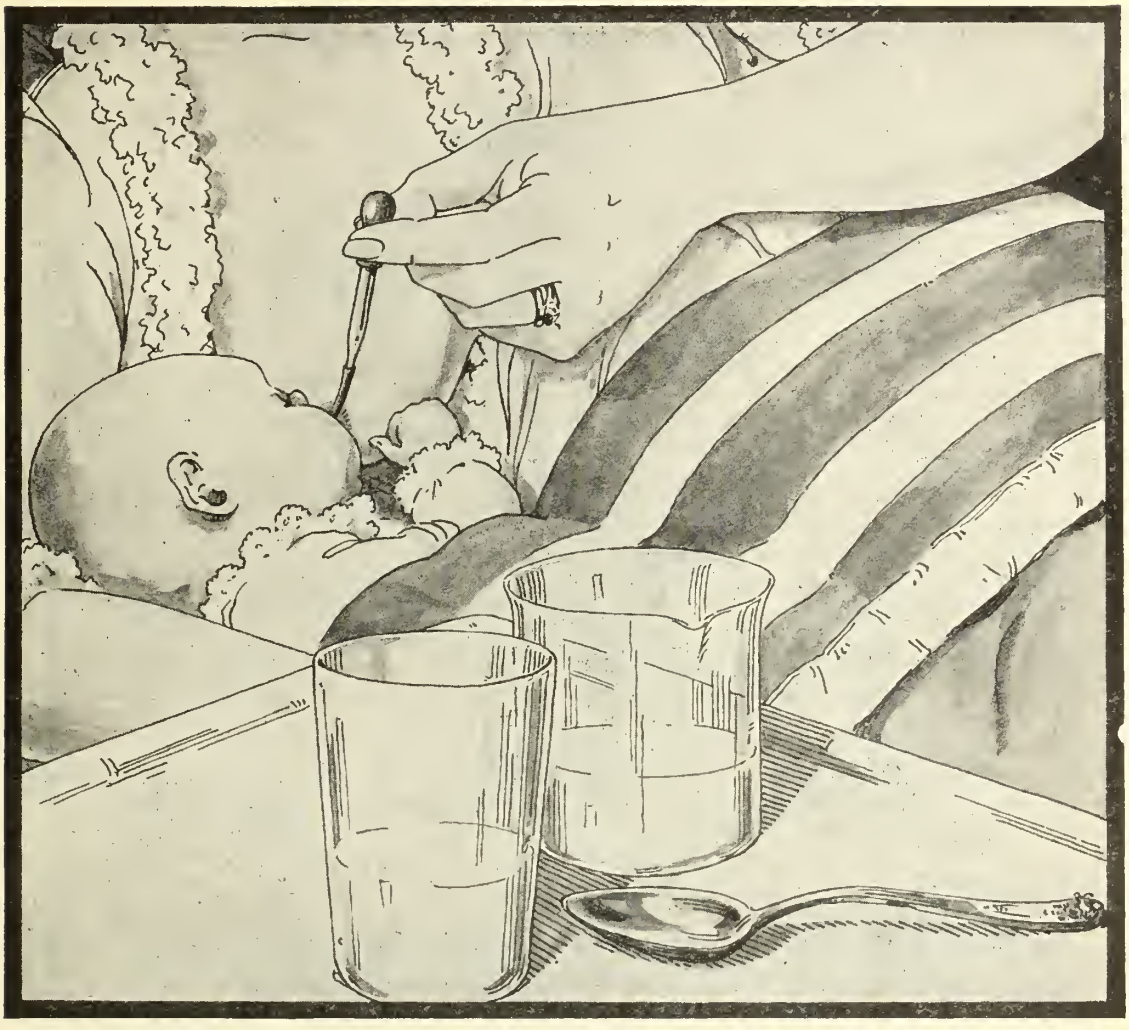


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PUBLIC HEALTH - SOCIAL WELFARE MEDICAL ECONOMICS and ORGANIZATION PROBLEMS

With Editorial Comment by D.K.M.

Strength In Organization Most Vital Now

Advent of the New Year, accompanied by world-wide unrest and widespread demands for radical social, economic and political changes, emphasizes the need for serious thought on the part of the medical profession relative to the future status of medical practice in this country.

The present abnormal and unsettled conditions and the possibilities of revolutionary changes, in the period of readjustment which will follow, have added materially to the complexity and seriousness of the numerous vital problems affecting scientific medicine, medical practice and public health.

Many leaders in the medical profession view the future with no small degree of uncertainty. Some harbor grave fears for the preservation of the fundamentally sound principles and traditions underlying medical service and medical practice in this country.

Analysis of some of the present-day conditions reveals many unfavorable signs for the future:

Acuteness of the world-wide economic depression continues with slight possibilities for an early recovery . . . poverty and privation increase . . . relief stations are crowded and welfare agencies taxed to the limit of their resources . . . hospitals and dispensaries are being filled with persons in destitute circumstances . . . extensive unemployment continues . . . physicians are overworked and their already lengthy list of charity cases doubles and triples . . . collections are slow and credits frozen . . crime increases.

Congress convening for what is predicted will be one of the most important sessions in the history of the nation, is flooded with paternalistic and socialistic proposals, sponsored by individuals ready to capitalize on the effects of the business depression and by organized agitators with the mistaken and false idea that government should become a great social-service agency and supercede individual initiative and enterprise in all fields of activity and endeavor. New bureaus, new departments, new divisions, new services are created as government is more and more centralized at Washington and local communities continue to relinquish more and more of their freedom of thought and activity. Taxes are increased to finance the additional activities of top-heavy government.

Reformers, uplifters, radicals and theorists promote and propagandize, seeking to turn the unsettled and uncertain situation into chaos and force a bewildered people into swallowing at a single gulp their varigated cure-alls. Statesmen and economists warn against the government dole while leading European nations attempt to salvage what they can from the rocks of dole-itis, socialism and communism. Sugar-coated theories and high-sounding programs, loaded with danger, are offered as palliatives to the confused wage-earner in exchange for his inherent right to think and act for himself.

The pressure for complete socialization of medical service, by the state or otherwise, increases. Open and subtle attacks on the medical profession continue. Impractical, unsound and dangerous proposals designed to solve problems relating to the costs of illness and the expenses accruing from sickness and injury are introduced. Experiments of questionable value in the field of medical and hospital service are started with little consideration for the quality of the service offered or the rights of the medical practitioner. Health and medical schemes which have proved failures in European countries are ballyhooed and exploited. Quacks, charlatans and cults flourish, cashing in on the criticism having a tendency to destroy the confidence of the public in the conscientious, ethical and qualified medical profession.

This is a sketchy but general picture confronting the medical profession as it turns toward the future.

What the ultimate outcome will be is highly problematical.

At present, some changes in the social, economic and political structure appear to be inevitable, possibly with more or less vital effect on the present status of the medical profession.

With this in mind, every physician should realize that there has never been a time when the need for strong, active and united medical organization has been more acute; courageous and able leadership in medical affairs more necessary; serious and thorough study and discussion of these important questions more vital, and vigorous and concerted action, based on conservative and sound judgment, more urgent.

What views the physician as an individual may have on these pending questions or what action he may take in a detached way to meet them will be of little effect unless the sentiment and efforts of the medical profession as a unit are coordinated

and initiated through organized procedure. Strong, active and united medical organization may be able to achieve much in preserving the social, economic and professional status of the medical profession as a group, and preventing changes that would be detrimental to public health and medical practice. Unless the issues are met with solid ranks and well-organized programs of activity, the results may be disappointing, if not disastrous.

The year 1932 promises to put organized medicine to the most severe test it has ever been called upon to face. It should have the active support of every physician who hopes for the further advancement of scientific medicine, cherishes freedom of thought and enterprise in the practice of medicine, and is interested in the preservation of and improvement in the health and welfare of the public.

Successful Health Conference

Conclusive evidence that Ohio, long a leader in official public health administration and activity, has kept pace with progress in the field of preventive medicine and is destined for greater achievements in the future is revealed by analysis of the thoughtful and serious discussions which took place at the recent annual conference of Ohio health commissioners in Columbus, and in interpreting the spirit of sincerity and enthusiasm which prevailed at the gathering.

As pointed out in a news article elsewhere in this issue of *The Journal* reviewing the high-spots of the conference, this year's gathering of official public health workers of Ohio not only established a record-breaking attendance but also provided health commissioners, public health nurses, and other workers in the public health field a splendid opportunity for discussing and reviewing mutual problems and laying a solid foundation for future activities.

Adequate proof of the interest and enthusiasm of the health commissioners of the state and their aides in important and vital public health questions is furnished by the fact that every county in the state was represented and that practically every city had one or more persons representing its public health department in attendance.

Much of the credit for the progress recorded in official public health work in Ohio belongs to the hard-working, earnest health commissioners of the state. They have been the key-men in health administration and have been a vital influence in coordinating activities which have made Ohio an example for other states in public health work. The fact that they are eager and anxious to convene for a serious discussion of public health questions and to improve their knowledge of the technical phases of public health administration indicates that the health of the people of Ohio is in safe and capable hands. It is quite likely that Ohio will continue to blaze trails for other states in this field of public service.

Educationally, the 1931 conference was outstanding. The program, which was a high mark for future conferences to emulate, consisted of papers and discussions on many of the everyday, but at the same time vital questions in public health work, including matters of policy, procedure and technic. The presentations showed much earnest thought on the part of the essayists. The spontaneous and spirited discussions which followed many of the addresses indicated that the official public health workers of the state are keenly aware of the questions confronting them and are well informed on the numerous problems arising in their field of service.

A predominate note struck throughout the formal and informal discussions was the widespread feeling among those in attendance that it is most essential that the mutual and cooperative understanding and relationship now existing between public health departments and members of their local medical profession be continued and developed. Many of those who addressed the conference were outspoken and frank in voicing the sentiment that successful public health administration depends fundamentally on the friendly and cordial relationship existing between the health department and the practicing physicians of the community. It was emphasized on numerous occasions that there should be a harmonious understanding between the health commissioner and the county medical society relative to the program and activities of the health department and that the health department should avoid procedures which would be antagonistic to or meet with the disapproval of the practicing physicians of his district. On the other hand, it was pointed out that where the health commissioner makes a sincere and earnest effort to cooperate with and enlist the support of the medical profession in practical public health projects, he deserves the aid and active interest of the physicians in his program.

Judging from the sentiments expressed on this essential phase of public health administration, Ohio is extremely fortunate in that there are but a few isolated cases of friction and discord between official public health departments and the medical profession. No doubt this is due to a large extent to the fact that an overwhelming majority of the health commissioners of the state are active members of their county medical society, well-informed about the policies of organized medicine, and firm supporters of the sound fundamental principles and ethics of scientific medicine and good medical practice.

Most of Ohio's health commissioners, especially those with considerable experience, have been quick to understand the necessity of avoiding pro-

jects, based on temporary fads and fancies, which detract from efficiency in public health administration and might be detrimental instead of beneficial to the public's health.

Realizing that public health work to be of appreciable benefit to the public must be sound scientifically and be based on the group thought of the medical profession, far-sighted commissioners also have arrived at the conclusion that balance is an essential factor in good public health work. There is a feeling among many of them that there is a growing need for a readjustment of public health programs in some communities.

As intimated by a number of conference speakers who, it would be fair to assume, were in a position to voice the group thought of the official health workers of the state, public health work has suffered in some localities because of the tendency on the part of some local health departments to curtail the vital, fundamental activities of public health administration and play up some of the newer, spectacular or specialized activities in the field of preventive medicine.

Even in communities where finances and personnel have been adequate to cope with these additional activities, many of them paternalistic and most of them affecting only a limited portion of the public, work in sanitation and communicable disease control, two basic factors in public health administration, has been neglected.

Fortunately but a comparatively few of the health departments of the state have permitted their program to become impractical and out of balance. The great majority of them are fully aware of the dangers in sacrificing fundamentals for non-essential undertakings, and of the fallacy of attempting to make standardized or theatrical programs fit local needs or meet varying local conditions. A lesson which has been well learned by the most of Ohio's health administrators is that an important part of the commissioner's work is to use his own initiative and own judgment in meeting local conditions and undertake only those projects which he is convinced will be of permanent benefit to his constituents.

A willingness and desire to cooperate with and receive the support of all individuals and groups sincerely interested in improving and protecting the health of the public was expressed on many occasions during the three-days meeting. However, there was a strong expression of sentiment against meddling in official public health administration by selfish and commercially-minded individuals and groups, and against efforts to force official public health administration to sponsor and undertake impractical, questionable or excessively socialized projects, promoted by groups with vague programs of activity, unsound scientifically and in conflict with experienced medical thought and established policy.

The spirit of the conference generally was well summarized by Dr. H. G. Southard, state director of health, in his annual address when he said:

"There is need for fewer up-lifting organizations, fewer departments, less duplication, fewer accidents, better health work preventing the preventable diseases that fill our state institutions with people who are mentally, morally and physically sick."

Panacea Practice

Under the somewhat ambigious title, "Progressive Medicine as It Is Practiced in California", Michael M. Davis, Ph.D., director for medical services of the Julius Rosenwald Fund, writing in the December issue of *The Modern Hospital*, describes some of the social and economic problems confronting the medical profession in California as observed by him on a recent trip to the Golden Gate state.

"One outstanding problem faced by the medical profession in California is the recent though growing prevalence of the system of paying for medical service on an annual basis", observes Mr. Davis. He then describes several of these systems, particularly one established by a large railroad for its employes and their families; another which is based on a contract between some 2,000 employes of one of the large counties of that state and a private group clinic to supply medical services in return for the payment of $2 a month from each employee, and another set up by a county medical society to furnish medical services on a fixed monthly payment basis for the employes of a large public utility corporation.

Dr. Davis also noted a mushroom growth of so-called "hospital and health associations" which sell medical service to individuals for so much a month, usually a ridiculously small amount, and are doing a land-office business.

Regarding this type of wholesale medical service, Dr. Davis writes:

"The law in California, or its present interpretation, appears to regard such arrangements as service contracts and not as insurance. Hence, these hospital and health associations are not under the supervision of the state insurance department and do not have to comply with regulations concerning financial stability, such as would safeguard regular insurance enterprises. The consequences seem to have been unfortunate for many of those who have purchased such services. Contracts, in some instances at least, seem to be so drawn as to carry a good many exceptions in fine print so that what the purchaser thinks he is going to get will not be forthcoming when he asks for certain medical care during his illness. * * * But the striking thing is that a large section of the public is so imbued with the idea of buying medical service in this way that such 'insurance' is salable. These associations

engage one or more individual physicians to supply the medical care, an arrangement that tends toward buying such service at a cheap rate and of poor quality."

Mr. Davis also deals briefly with the serious question in California relative to the numerous sects and fake healers, intimating that the medical profession there has practically conceded defeat in its attempt to deal with this problem.

The situation in California as described by Dr. Davis illustrates the wide variety of methods and schemes now being tried, not only in one state but in different sections of the country, to meet changing social and economic conditions.

While it seems inevitable that additional changes in medical practice and medical services will be necessary in the near future, it is doubtful if "progressive medicine as it is practiced in California" has added anything beneficial toward a general solution of these problems, either from the standpoint of the public or of the medical profession.

Dr. Davis' article is, at least, thought-provoking. It should stimulate serious consideration among physicians generally regarding the weird and fallacious schemes that are being tried to meet a questionable "public demand" for medical service at bargain-store rates by corporate lay interests.

The weakness of the methods which have attained temporary vogue in California first of all lies in the fact that they are being popularized in a state where cultism and quackery have flourished.

Secondly, there seems as yet to be little information available regarding the quality or abuses of the services being rendered by the various agencies which have tended to supplant the practice of medicine by individual physicians in many communities of California.

In the final analysis, the one outstanding factor that must be taken into consideration by the medical profession and the public in any endeavors to bring about a readjustment of medical service and medical practice to meet actual or theoretical conditions is the preservation of the high quality of service which is now being rendered through the individual and competitive practice of medicine.

How Shall Specialists Be Determined

Discussion at the forthcoming annual Congress on Medical Education, Medical Licensure and Hospitals at the A.M.A. headquarters, Chicago, relative to the regulation and licensing of specialists will be watched with considerable interest by the medical profession generally, educators, and a goodly portion of the public since this question has in recent years become a topic of increasing interest.

The contention has been made that many of the specialties are overcrowded, that too few younger men are entering the field of general medical practice, and that a portion of those taking up special lines are inexperienced and untrained in the special branch selected by them.

Medical leaders are practically unanimous in their opinion that something should be done to remedy certain evils in the present situation. On the other hand, there is a sharp difference of opinion relative to the best way of regulating the specialties so as to adequately protect the public from unqualified practitioners and to keep medical standards high.

There is no doubt but what the wise thing for those who favor setting up regulatory methods for specialists to do is to make haste slowly and devote serious consideration to all angles of the question.

Pointing out the extreme importance of this question and the necessity for thorough study of the problem before standardized methods are adopted, Dr. Harold Rypins, secretary of the Board of Medical Examiners of the State of New York, writing in a recent issue of *The Bulletin of the Federation of State Medical Boards*, says:

"It must not be forgotten that with the increasingly high standards of medical education and the almost universal custom of intensive intern training which the young physician now receives, the American public is being adequately supplied with very competent young physicians whose training enables them to properly perform services which formerly required a specialist's training. Furthermore, the problem of retaining young and active physicians in rural districts is a pressing one and it would be very dangerous to restrict the type of practice of the rural practitioner who, more than any one else, must exercise almost every kind of medical and surgical skill."

Dr. Rypins refers to the serious attempts being made by a number of the national organizations of specialists to solve this problem by conducting examinations which would entitle those who pass to hold themselves out to the public as qualified specialists by virtue of their membership in these special societies. He also calls attention to the fact that several academies of medicine and county medical societies are issuing annually lists of members who are qualified in the various specialties. Dr. Rypins believes that greater emphasis on systematic postgraduate instruction in the specialties by the leading medical schools would go far toward solving the question. He indicates that he believes a system of licensure for specialists by state examining boards would be undesirable and impractical.

The Mortality of Gall Bladder Surgery

FREDERICK C. HERRICK, M.D., Cleveland, Ohio

STATISTICS, and especially those referring to surgical mortality, are proverbially fallacious. If we include *all* operated disease of the gall bladder and bile ducts; cancer, cases admitted in extremis with ruptured gall bladder and general peritonitis, as well as those perhaps operated elsewhere with some untoward condition, as fistulae and adhesions, as a result, these take the joy out of our *good* results. Again, ruling these out, if we stick closely to our own cases as diagnosed with pre and post operative care, we can have greater pleasure in a very low mortality of 1 to 2 per cent. From another viewpoint, if, as was believed by the surgical world exulting in its technical accomplishments, gall bladder disease was limited to that organ, we should show practically no operative mortality.

However, surgery has shown that gall bladder disease is only a local manifestation of a widespread infection, and a widespread effect, or toxemia of a local infective and biochemical disturbance. When we thoroughly appreciate these two facts, we shall be on the proper basis, for the treatment of the gall bladder complication, for surgical disease of the gall bladder is a complication of a wider spread infection from a distant focus or the gastrointestinal tract and a pathological hepatic physiology.

A preoperative complete estimation of the patient's physiological balance and a preoperative therapeutic course will remove certain causes of post operative complications.

We have at present no accurate method of diagnosing pancreatitis. An experienced clinical judgment is right in a fair per cent of cases, but chronic or even acute pancreatitis is too often diagnosed first at operation or autopsy, and yet it is associated with gall bladder infections in 20 to 25 per cent of the cases and offers a marked cause of delay in recovery.

CHOLECYSTITIS, GALL STONES, PANCREATITIS

C. H. L-861. W. F. Age, 58 yrs. Adm. 3-6-31.

C. C.—For the past three or four years, the patient has had dull pain at McBurney's point, no vomiting, no acute attacks. The pain was well localized at this point with rather marked tenderness and muscular rigidity.

During the present winter, she has been very active, and for the past three weeks, she has felt restless, tired easily, fatigued, with some palpitation of the heart, and dizziness with headaches.

There has been no loss of weight. Appetite good. No evidence of dyspepsia or indigestion of any kind. Her bowels have been costive.

P. H.—Always in good health. Typhoid fever at 22 years of age. Her cardiac, pulmonary, pelvic and genito-urinary history is entirely negative.

P. E.—Well nourished. B. P.—140/86.

W. B. C.—8,600. Blood chemistry—Urea Nitrogen—15.4. Creatinin—1.1. Basal metabolism rate was, plus 13.

Examination of the abdomen showed no tenderness over the epigastrium or over the gall bladder and no masses palpable. The diagnosis of the physician referring the case, was chronic appendicitis, which was concurred in.

Operation: 3-18-31. Right rectus incision. Appendix removed, but it was obviously not the seat of trouble. Palpation of the gall bladder revealed stones. Incision extended upward. Inspection of the duodenum and stomach was negative. Palpation of the kidneys and spleen was negative. The pancreas felt slightly enlarged, though of normal consistency. There was no fat necrosis. It was considered normal. The foramen of Winslow was patent. The gall bladder was removed from below up. Closure with small tube drainage.

Post operative course: On 3-19-31 and 3-20-31 dressings were slightly bile stained. The fluid intake from the 18th to the 23rd, when the patient died, ranged from 3325 c.c. on the 19th to 1285 c.c. on the 23rd. The output varied around 1000 c.c. for each 24 hours.

On the day following operation, the patient had glucose 5 per cent, intravenously. After 60 c.c. were taken, she had a severe chill lasting one-half hour. The glucose was discontinued and saline substituted. Her temperature, however, did not reach normal from this time.

The death strongly suggested pulmonary embolus. However, autophy showed an extensive fat necrosis of the pancreas, and the gall bladder specimen showed positive culture of staphylococcus.

In this case, there was an inaccuracy of diagnosis. If the condition of the pancreas had been appreciated, and proper common duct drainage established, there might have been a different termination, since regurgitation of bile into the pancreatic duct is one of the well-known causes of pancreatic necrosis. Infected bile activates pancreatic secretion, and when this occurs in the pancreas, a necrosis of the organ results.

We are reminded of the practice of Mayo-Robson who used cholecyst-duodenostomy as a standard procedure in chronic pancreatitis or even in questionable cases. More recently, if you will remember, Du Bose has used cholecyst-gastrostomy as a therapeutic procedure in gastric and duodenal ulcer and reports success. This, of course, would be gained by alkalinizing of the gastric secretion by the bile and its presence in digestion, but a free drainage at least of the common duct, whether to the surface or to the intestine is indicated in all infections of the bile tracts. So far as closing cholecystectomies without drainage is concerned, it is refreshing to see

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that Fowler and others in more reeent studies have shown that there is a lower mortality following *drainage*, and a more permanent benefit from the operation.

Had our diagnostic methods been able to show before or during operation the eondition of this patient's panereas, drainage of the eommon duct would have been benefieial, and perhaps life saving.

THE PROGNOSTIC VALUE OF ISO-IODEIKON

The work of the Graham staff in choleeystography, and its value is past question. The more reeent effort of these workers to establish a functional eapaeity test of the liver is, however, subjeet to a great deal of question.

With the view of testing out the value of Iso-Iodeikon as a hepatie funetion test, we used the substance following absolutely the technique suggested by its author and as he suggested a single man was delegated to make all of the observations.

We find that "Tetradol" has shown many splendid results in visualizing the gall bladder, and that it is of value as a diagnostic proeedure in about 94.9 per eent of 119 eases. Of six errors, two we found to be duodenal uleer, and four showed no disease.

We feel that Iso-Iodeikon (Phentetiothalein Sodium) adds nothing to choleeystography; that it is of little or no value as a liver funetion test, and finally, that we have seen several severe reaetions following its use.

As a liver funetion test the following cases are illustrative of its inaeeuraey:

INTERPRETATION OF RESULTS

A retention of about 10 per cent of the dye one-half hour after injeetion, and about 5 per eent, or less, one hour after injection is eonsidered normal. The greater the pereentage of dye retained in the serum, the more severely impaired the liver function. The largest amounts of dye retention have been found in patients suffering from acute cholangitis and hepatitis, such as that encountered in aeute eatarrhal icterus. In some eases of severe cholecystitis, the amount of retention may be as high as 80 to 90 per eent.

CHOLECYSTITIS

C. H. K-3948. W. F. Age 48 yrs. Adm. 10-5-30.

CC—Patient gives a typieal history of flatulent indigestion of the gall bladder type, with attaeks of biliary eolie of several years duration.

Cholecystograms showed evidenee of gall bladder pathology and gall stones.

Iso-Iodeikon, liver funetion test showed a retention of 40 per cent in one-half hour and 15 per cent in an hour.

The patient was plaeed on the usual eliminating pre-operative routine for one week. She was considered in excellent condition for operation. The gall bladder was removed and she made a eompletely uneventful recovery.

Before leaving the hospital, her liver function test showed a retention of 35 per eent for the half hour and 12 per eent for the hour.

It is perfectly apparent that this patient made a completely uneventful reeovery, in spite of the faet that the liver funetional test was questioned aecording to the method.

CHOLECYSTITIS, COMMON DUCT STONE

C. H. K-3633. W. F. Age 65 yrs. Adm. 3-28-30.

This patient has a typieal history of eholeeystitis, whieh was supported by eholeeystograms. The gall bladder was removed. Palpation of the common duet revealed no stones. The eommon duet was not drained.

The pathologieal report was subaeute and ehronie eholeeystitis without stones. 10-18-30 the patient was readmitted.

CC—Persistent epigastrie pain of typieal gall bladder type, elay eolored stools and jaundiee, whieh had been present off and on, sinee leaving the hospital after her previous operation.

Iso-Iodeikon liver function test showed 30 per cent retention during the first half hour, and 20 per eent during the hour.

We had by this time learned that sueh a liver funetion test was of no serious meaning.

The general condition of the patient was excellent, and her blood ehemistry was normal, therefore the seeond operation was proeeeded with.

Operation: 10-19-30. There was a large amount of conglomerate material, soft, whieh was removed from the eommon duet. No stones were palpable. The eommon duet was drained and the patient made a good reeovery.

STONE IN THE COMMON DUCT, PANCREATITIS

C.H. K-2073. W.F. Age 68 yrs. Adm. 5-27-30.

CC—Patient gives a history of relatively painless eommon duet obstruetion, though there is some history of pain beginning baek several years ago. Jaundiee of intense grade of three weeks duration. General weakness.

Iso-Iodeikon liver function test showed a retention of 17 per eent in the first half hour, and 6 per eent in one hour.

Choleeystograms showed evidence of gall bladder pathology.

Operation: 6-23-30. Right rectus ineision. The gall bladder was small, hardly distinguishable. One stone was felt in the common duet at the ampulla. Palpation of the panereas showed it to be inereased in consisteney, somewhat irregular. Cholecysteetomy, removal of the eommon duct stone through a posterior duodenal approaeh. The stone was one cm. long, pure cholesterin. Closure with drainage.

The patient made a good recovery.

Our reactions noted have been both general and loeal, the latter due to technical error and should be avoided. Eseape of the ehemieal into the tissue produees a severe inflammatory reaetion, but no slough. The reaetion eleared up in a few days of hot packs.

Venous thrombosis occurred in several eases.

The general reaetions eonsisted of severe urticaria and erythema, of sub-normal temperature and depression in one patient of seventy years lasting for several days, but clearing up without

CASE REPORTS—ISO-IODEIKON

K-3948	½ hr. — 40% 1 hr. — 15% ½ hr. — 35% 1 hr. — 12%	F — 48	3-yrs.	Chr. Cholecystitis	R Disch. on 15th P. O. day
K-3633	½ hr. — 30% 1 hr. — 20%	F — 65	6-mos.	None made	R Disch. on 41st P. O. day
K-2073	½ hr. — 17% 1 hr. — 6%	F — 68	5-days	Cholecystitis Common Duct stone	R Disch. on 28th P. O. day
K-4211	½ hr. — 50% 1 hr. — 25%	M — 51	6-mos.	Cancer of pancreas Intense brown Jaundice	R
K-4538	½ hr. — 60% 1 hr. — 10%	F — 55	15-yrs.	Chr. Cholecystitis & Lithiasis	R Disch. on 16th P. O. day

further trouble. We could appreciate a result more serious.

It is perfectly evident from these cases, that retention of Iso-Iodeikon is no indication whatever, that the liver is not functioning sufficiently for major surgery. It is no contra-indication to operation.

As a step toward rationalizing the handling of such cases, liver function tests are much under discussion. Functional tests may be rated as negative or positive. Negatively, we test an excretion function by showing an accumulation of excretory products. Positively, we introduce a substance which we think should be excreted by the organ in question, and measure the work done or not done. The great criticism of the dye tests for *renal* function is, that we are measuring the renal function capacity by excreting a substance which is not a part of normal biochemistry. That the dye is excreted through the glomerulus as a foreign body, the passage of a soluble filtrate is certainly no evidence that the glomerulus is normal and certainly no test that the tubules are either excreting or concentrating.

To a much more marked degree, this would seem to be true of the attempted measurement of the liver function by a dye test. The liver carries on at least seven different biochemical functions (ureagenic, glycogenic, lipasic, antitoxic, sanguinopoietic, thermic, ferric) each on a biochemical substance brought by its two circulations to specialized cells, and none of these changes is a filtration. How, then, are we to measure such a capacity by the use of a soluble, diffusible dye?

Dye tests of liver function are subject to the same error as those of renal function, i.e.

1. An unphysiologic demand.

2. The various liver functions are accomplished by different cell groups; hence, a foreign substance cannot be equally elaborated by all.

3. A dye is not a secretory, but a filtration test.

Regarding the present possibilities of clinically accurate liver function tests, Mann summarizes as follows:

1. All bilirubin formed in the body is readily excreted by a *small* part of liver tissue.

2. Partial removal of the liver has little demonstrable effect on dye excretion.

3. Carbohydrate metabolism is also not affected by liver removal except in a slight increase of blood sugar.

4. Marked changes in proteid metabolism, retention of urea nitrogen, amino acids or ammonia, are very difficult to demonstrate. A uric acid retention is the only form of nitrogen disturbance demonstrable.

McLeod and others have demonstrated carbonate retention.

5. A detoxifying function can be demonstrated in animals.

Finally, "the amount of uric acid excreted in the urine appears to bear a very definite relation to hepatic damage." (Mann).

An animal can survive removal of the liver or short circuiting its portal circulation (Eck fistula) for many weeks if all proteids are withheld from its diet. If proteids are given, death occurs in coma or convulsions. On the other hand, I autopsied a case of hepatic cirrhosis, of many years standing, in a woman of eighty years of age, which showed a small hard liver of 400 gms. weight, without ascites, with an extensive collateral circulation. This patient had lived in good health on a most meagre carbohydrate vegetable diet for many years.

She was of very spare build, weight 85 lbs., and apparently had only sufficient liver cells to maintain her physiological balance with her non-proteid diet.

Individuals without the usual liver volume stand a carbohydrate diet better, because such are used up in the tissues and muscles, and toxins from incomplete digestion are not formed.

The amino acids and carbamates of proteid origin passing directly from the intestine, produce a fatal toxemia. In the hepatitis associated with bile duct infection, it must be hypothecated that an intermediary toxic substance is formed, giving us the symptoms of hepatic insufficiency.

I shall omit, because of time, a discussion of disease in other organs and post-operative complications.

PREOPERATIVE CARE

1. Proteid food is reduced to a minimum by removal of all meats from the diet. In plethoric, over fed, over weight patients, a special very limited diet is allowed, which together with the routine results in a weight loss as high as fifty pounds.

2. Increase in fluid intake to 3-4000 c.c. in 24 hours.

3. Free catharsis—after a primary of castor oil—sodium phosphate before each meal in a glass of hot water.

4. The above is carried out with variations and duration of time, from a day or two to several weeks, until clinical and laboratory findings are as nearly normal as is possible for the patient.

An emergency operation is the last procedure desired. Even, if, in the rare case such is thought necessary, the 24 to 72 hours of preparation by infusions and elimination are of great value.

POST-OPERATIVE CARE

Our routine in post operative care is, accordingly, very simple, and comprises morphine and saline or glucose infusions.

We have seen several cases in which glucose administration was followed by a chill, necessitating discontinuance, and wonder if this is not more common with an associated pancreatitis.

If our patient is carefully prepared, or in the optimum condition, the convalescence is most comfortable.

1. Gall bladder surgery is rarely urgent. The long time and repeated reinfection from the intestinal tract, the resistance of the liver to infection by its detoxifying function, the ability to recuperate repeatedly from each injury when eliminative measures are adopted, give us a full opportunity to select our time for operation.

2. A clinically valuable functional capacity test of the liver must be based upon a better understanding of its chemical physiology.

3. A complete evaluation of the patient's condition, including blood chemistry, CO^2, and counts, together with sufficient rest and elimination to detoxify, are essetnial.

10515 CARNEGIE AVE.

DISCUSSION

ALBERT LOVEMAN, M.D., Cleveland, Ohio: It is with considerable trepidation that a young medical man arises to hold a discussion with so well known an author and surgeon as Dr. Herrick, particularly after so fine a paper as he has just given. But our personal experience with seventy-two injections since April, 1930, in the wards of Mt. Sinai Hospital has given a somewhat different feeling about intravenous liver function and cholecystography than has Dr. Herrick's.

No reactions occur if the dye is given immediately after preparation, and diluted up to 150 c.c. with saline solution. If, however, there is delay, minor reactions do occur, these consisting chiefly of urticaria. We have met no other reactions, but I must, again, advise immediate administration. No contra-indications were found, the dye being given in jaundice, cardiac failure and coronary disease.

We have found several advantages in the intravenous method over the oral:

1. Less discomfort to the patient. This has been very apparent to the nurses on the wards and to those patients who had the dye by both methods, there being no nausea, vomiting, cramps, nor diarrhea.

2. Deeper shadows of the gall bladder which is particularly valuable in those cases of cholesterin stones in a good functioning gall bladder, the greater concentration showing the stones as negative shadows. We have had two cases in which oral method showed no stones and the gall bladder filled, in which the intravenous route clearly outlined the stones.

3. Cardiac cases, with chronic passive congetsion of all the organs, the liver tenderness, and the indigestion, frequently lead the clinician to suspect the gall bladder and is assisted in the suspicion by non-filling of the gall bladder, after oral dye, there being no absorption in the gastro-intestinal tract. I have seen such cases operated, before the use of intravenous method. In these cases the intravenous method gives high retention in circulation, but good shadows of the gall bladder.

4. In cases of peri-cholecystitis (which, by the way, frequently has typical colic, without stone), there is impaired excretion of dye with a gall bladder shadow of considerable density and sometimes irregular outline. By the oral method we know nothing of the liver function and the diagnosis is therefore more difficult.

Graham has stated that an individual whose liver function is 60 per cent or less by this method, is a poor risk for operation. We have respected this, excepting in one case, with disastrous results. A patient who had an infectious hepatitis was subjected to exploration and succumbed 36 hours after operation in which nothing was done except the opening of the abdomen. Liver function test done on the morning of the operation revealed 50 per cent retention in one-half hour. I call attention to the fact that his test was done on the same morning of the operation, for if determinations are made some time before operation, one cannot say what the function of the liver is at the time of operation because the liver has great powers of regeneration, and also varies its function with infection and toxic agents very quickly. Particularly must the time interval between the test and operation be checked, since the use of glucose is almost routine in preparation for operation, and as recuperation of the liver is markedly accelerated by its use.

We have used the test in non-surgical liver diseases such as so-called alcoholic, luetic, arsenical, cincophen hepatitis, and in acute infectious hepatitis, and found the impaired excretion of dye to be a better test than the presence of increased bilirubinemia and the presence of increased amounts of urobilinogen in the urine.

In conclusion, along with all other tests this one is not perfect, and we believe its use is of aid in diagnosis and prognoses of liver and gall bladder disease.

The Course and Prognosis of Arthritis

R. M. STECHER, M.D., Cleveland, Ohio

A STUDY of the literature on arthritis discloses such a variety of opinions concerning the etiology, physiology and proper treatment that the student is soon overwhelmed by contradictions and confusions. Admitting the truth of these various factors, it is incomprehensible that they all contribute to each case. Discrimination is necessary to discern to what extent different mechanisms contribute to individual cases. While a clinical study of a group of arthritics scarcely can be expected to reveal anything original, it may emphasize etiological factors, contributing causes, general course of the disease, and principles of management.

I am presenting today observations made on a group of about forty-four cases of arthritis seen on the medical wards of Cleveland City Hospital during the past eighteen months. Acute rheumatic fever, tuberculous disease of the joints and asymptomatic hypertrophic nodes and spurs have been omitted. That this series may differ from another is freely admitted. No claim is made that all types of arthritis have been observed. Nor is it suggested that all possible diagnostic tests or therapeutic measures have been exhausted. In spite of limitations, several conclusions seem worthy of emphasis.

The cases have been divided into two groups, based solely on the duration of the disease. In the first group are considered patients whose continuous history lasts two years or more. The second group includes the more acute cases, with a duration of under six months. Such grouping in a clinical study seems justified because the type of onset, prognosis and problems of treatment are sharply contrasted.

Fourteen cases fall into the first group. Five were females and nine males. The average age when first seen was forty-six years, ranging from nineteen to sixty-three. The average duration of disease when first seen was 5.7 years, ranging from two to fourteen years. Three of the cases, all males, were classified as hypertrophic in type, the rest were considered to be atrophic in type. Pain was almost a constant complaint in this group, being noted in eleven of the cases. Contractures of such an extent as to preclude the use of limbs were observed in six patients. This was the only complaint in two cases and had they been prevented these patients might have been comfortable and useful members of society. Two patients had marked joint effusions. Five patients exhibited fever during their hospital stay.

The mode of onset in this group was usually described as gradual, slow or intermittent. Only one patient recalled having had a sudden onset with fever. Foci of infection in many of these patients had been treated, because of arthritis, before they entered the hosiptal. Nine patients had had dental extractions. Six of them had had tonsillectomies. Five patients had significant and prolonged fever in the hospital despite the fact that four had already had tonsillectomies and three dental extractions, and that their average duration of disease was seven years. Tonsillectomy was performed on two of these patients and dental extractions on three. Of the fourteen patients, two submitted to tonsillectomy and six had dental extractions. Clumped pus with various forms of bacteria was found in six of the seven prostates examined and was treated by prostatic massage.

Treatment, aside from care of foci of infection, as described, consisted largely of baking, massage and orthopedic measures. All had periods of bed rest which alone often gave some relief of pain. Analgesics were used as indicated.

The results in this group were not especially encouraging. Two patients died under observation, one of cardiac failure following prolonged and severe hypertension, the other of miliary tuberculosis after eighteen months of extensive ankylosis and marked invalidism. Five patients were definitely improved so that their range of activity and general comfort was increased. Four patients derived no benefit during their hospital stay, and three are still being treated. Even more was accomplished however, than these figures indicate. The man with extensive ankylosis, who subsequently died, was absolutely helpless when first seen. After several weeks of baking and massage his arms improved sufficiently to allow him to feed himself and read a newspaper. He never became a useful citizen under our care, to be sure, but I feel we contributed greatly to his meager share of remaining happiness.

A girl with Still's disease of ten years' duration had a dislocated wrist, two hammer fingers, fixation between the left humerus and scapula and had pain in many of her muscles. Her tonsils had been removed and she had lost three teeth. In the hospital she had a little fever and after a great deal of deliberation, a doubtful upper molar was removed. The socket drained pus containing streptococci for about three weeks, after which her temperature became normal. One hammer finger was straightened with a banjo splint, the shoulder regained normal function under physiotherapy, she gained weight and her general condition improved. Her greatest complaint had been pain in her feet on standing or walking.

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Physiotherapy and muscle training resulted in marked relief of this symptom.

The group of early cases included thirty patients, nineteen men and eleven women. The average age of this group was thirty-eight years and the average duration of disease, when first seen, was five weeks. The past history of patients in this group disclosed the fact that six had had one or more attacks of inflammatory rheumatism or arthritis with complete recovery. Five patients had had attacks previously of sinusitis, tonsillitis, or sore throats, and six patients had had gonorrhea. Predisposing causes which seemed of significance in regard to the onset of the present attack were exposure to cold, chilling or wetting in nine cases. Seven cases began after some genito-urinary disturbance, as urethral discharge in three, and one each of leucorrhea, vaginal abscess, abortion, and prostatic massage. The onset, in fourteen cases, was acute with chills, fever, headache or backache. Multiple joints were almost universally involved with migration in the beginning, though later the process usually settled in one or several joints. The combination of sudden onset with chills, fever and migratory arthritis was so marked in six patients that a tentative diagnosis of acute rheumatic fever was made, to be corrected later because of lack of response to salicylate, absence of cardiac involvement and chronic proliferative changes in the joints.

Fever reaching 38° C. for at least one week was noted in twenty-two cases. Occasional fevers as high as 40° or over were encountered, and prolonged fever from 37.5° C. to 38° C. was extremely common. Such slight elevations of temperature seemed significant, for symptomatic improvement of joints often was delayed until such temperatures fell to normal. Leucocytosis on admission was seen as high as 42,800 in one case. The white blood count was over 14,000 in seven cases and over 10,000 in eighteen cases.

With the presence of infection suggested by fever and leucocytosis it seemed necessary to search it out and treat it, if possible. Consequently, dead teeth were removed from eleven patients, eight tonsillectomies were performed and sixteen of nineteen men showed clumped pus in the prostatic secretion, treated by massage. Seven of these cases of prostatitis were gonorrheal in origin and three women were treated for gonorrhea. Other occasional sources of infection which were felt to be related to the arthritis were sinusitis, cystitis and bronchiectasis.

The results observed in this group of cases is instructive. Of thirty patients, two resulted in death. In both cases the onset of arthritis was precipitated by a fall and injury to one joint, followed by pain, swelling, inflammation and persistent fever. Death ensued from generalized infection ten and sixteen weeks after injury. It seems unreasonable to consider these as fatalities due to arthritis as the joint involvement was only a part of a much more serious process. Five patients left the hospital against advice, so they could not be followed. Two of these left because of disagreement concerning removal of obviously abscessed teeth, two were constant troublemakers, and one because of other illness at home. Twelve patients were discharged well. This term is used here to indicate a free movement of joints of sufficient range to perform usual functions without pain. They could stand normally, walk without a limp, and climb stairs naturally. They could feed themselves, get their hands behind their necks, and work. Seven patients were considered improved. This group was free of pain but had some noticeable limitation of joint motion. Two were considered unimproved for they had persistent pain. In two patients, ankylosis of several joints occurred.

The duration of the attack is best studied from the group treated in the hospital. Excluding two fatalities and five discharged against advice, eighteen patients were considered. These were not discharged until they had at least two weeks of normal temperature and at least one week of total freedom from joint symptoms, or the symptoms had become stationary. Inasmuch as eleven of the twelve complete recoveries occurred in this group, the prolonged period of care seemed justified. Two patients stayed over thirty weeks. The first, a girl with gonorrheal arthritis resulting in ankylosis, was kept for thirty-seven weeks; the other, a man with persistent fever and joint symptoms, finally made a complete symptomatic recovery in thirty-four weeks. Excluding these two protracted cases, the average hospital stay of the remaining sixteen cases was only nine weeks.

In commenting on these cases, several factors must be kept clearly in mind. The group is too small to warrant conclusions about various types of cases of arthritis, and their relative proportions. The duration of the study is too short to warrant conclusions about the natural evolution of disease in regard to recurrent attacks. Conclusions about the duration of individual attacks, factors precipitating the onset and influencing the course of the attacks by therapeutic measures are justified.

The duration of the disease appears a most important factor in judging prognosis. The longer the duration, the poorer the prognosis. This may be due to the fact that the more severe or more chronic cases persist. Also, the duration determines in individual cases the degree of joint damage and the difficulty of remedy. Neglect, however, may prolong the disease and prevent recovery. This is judged to be the case because of the number seen with duration measured in years with fever and easily recognized infection. Satisfactory treatment of in-

fection at this stage leaves us still with troublesome contractures.

The treatment of contractures is an orthopedic problem but their prevention is strictly a medical responsibility.

No attempt will be made to cover the very broad and controversial subject of treatment in arthritis, but it is desirable to emphasize those factors which appeared of importance in this group. One element of treatment often overlooked is that of rest. Bed rest is indicated for various periods depending on fever, inflammation and infection. The patient often exhibits amenia, loss of weight and strength, and general debility which, in cases with an insidious onset, may become extreme before proper concern is exercised. An inflamed joint is also deserving of rest. Rest, however, in inflamed joints favors ankylosis so that passive motion is in order where not contra-indicated by pain. There is a great deal of difference between passive motion and weight-bearing in their effect on an inflamed knee. But when pain makes passive motion harmful the prevention of contractures becomes doubly necessary. This is done by traction, extention, or even by splints. Much joint pain in the acute stage is due to muscle spasm protecting the joint from motion. Proper supportive apparatus protects the joint from motion and allows relief of muscle spasm. Great care must be exercised to start motion through as wide a range as comfortable, as soon as possible. With arthritis of the spine, contractures of the neck can be avoided by having the patient lie flat without a pillow. Contractures of hips and knees can be avoided in the bedridden patient by constant attention and care.

The discovery and removal of foci of infection is often difficult. The recesses of the body which may harbor infection are seemingly without number and their prompt and certain discovery demands an eagle eye and sensitive finger, as well as some imagination. In spite of added attention directed at the importance of foci of infection, it no longer is justified to remove all the teeth, puncture all the sinuses, or subject the patients to removal of appendices, gall bladders, or genital organs on general principles. I believe firmly that dead teeth should be removed. It is just as important, however, that well preserved and vital teeth be saved. The presence of full upper and lower plates even of years of service is no guarantee, however, that broken off and buried infected dental roots may not be revealed by *X*-ray.

Tonsillectomy was done in ten patients, all of whom showed persistent fever or joint inflammation. In eight cases, marked relief ensued. Within twenty-four hours several patients enjoyed marked relief of muscle spasm, joint pain, and had increased range of motion. Three patients, thought to have gonorrheal arthritis, improved promptly after tonsillectomy.

The greatest surprise of this study was the incidence of prostatic infection. Twenty-two men out of twenty-five examined, had clumped pus with various organisms in prostatic secretion—an incidence of 88 per cent. Seven of these showed evidence of, or gave a history of gonorrhea. These patients were treated by repeated massage.

The successful treatment of arthritis demands constant attention to the patient to conserve his energy and aid nature in her healing, a resourcefulness and energy tempered with good sense in discovering and eradicating the infection so frequently present, and a constant watchfulness to preserve joint function and prevent deformity. If these principles are attended to promptly and conscientiously, I believe results will improve, restoration to health will be hastened, and deformity and disability will be decreased. The course of the disease is often slow. The patience and hope of the doctor and patient are frequently tested to the utmost, but physicians must accept the challenge with courage. My own modest experience emphasizes more and more the words with which Penberton closes his book on arthritis, "The impression still prevails in many quarters that arthritis is an incurable disease, whereas in fact there are few disease states for which more can be done."

CITY HOSPITAL.

Edward M. Van Cleve, principal of the New York Institute for the Education of the Blind, New York City, a native of Ohio, and former superintendent of the Ohio Ohio State School for the Blind, has been awarded the Leslie Dana Gold Medal, given annually for outstanding achievements in the prevention of blindness and the conservation of vision by the National Society for the Prevention of Blindness in cooperation with the St. Louis Society for the Blind. Mr. Dana, donor of the medal is a resident of St. Louis. Mr. Van Cleve was born in Ohio in 1867, educated at Ohio Wesleyan University, taught in the public schools of Ohio for a number of years, and served as superintendent of schools in several communities of Ohio. In 1907 he was appointed superintendent of the State School for the Blind and later served as president of the Ohio State Commission for the Blind. In 1915, Mr. Van Cleve took a leading part in the formation of the National Society for the Prevention of Blindness and became its first managing director, an office which he held for nine years.

Annual Congress on Medical Education, Medical Licensure and Hospitals, conducted by the Council on Medical Education and Hospitals of the American Medical Association, will be held February 15 and 16 at Chicago.

Report of a Case of Acute Yellow Atrophy of the Liver Due to the Use of a Small Amount of Cincophen

S. C. LIND, M.D., Cleveland, Ohio

CINCOPHEN has come into such general use that the reporting of a case of acute yellow atrophy of the liver apparently resulting from an insignificant quantity of this drug seems obligatory. Physicians prescribe cincophen with great freedom. It is sold by the druggist to any purchaser, and is contained in certain proprietory rheumatic "cures". A number of deaths resulting from cincophen poisoning have been reported, but a larger number are unrecorded. I know of a number of such that have occurred in Cleveland, but which have never been reported. If the profession is to be made acquainted with this danger, full publicity must be given these fatal cases.

On November 26, 1930, a colleague asked me to see his wife since he feared that she would require an operation for gall-stones. During the night he had administered two doses of morphine in an attempt to relieve her abdominal pain. Distressing vomiting had occurred from time to time.

The patient, aged 39, was the mother of four children, three of them were living and in good health. She had never been ill, except for one attack of malaria, contracted ten years previous, while living in the tropics. Close questioning failed to disclose any other sickness. The husband assured me that she had escaped all diseases of the tropics except malaria. The patient had been severely constipated for years, but in other respects considered herself in excellent health. Through moderate dieting she reduced herself from 185 pounds to 145 pounds. Both the husband and wife stated that the diet was not greatly restricted, that she ate a variety of foods at each meal, but in a somewhat limited quantity. She did omit a ten o'clock lunch at night, which she had been in the habit of eating. She said that she had always been a "big eater". This diet was begun in March, 1930.

The state of health was excellent until October. She played golf several times a week all summer, looked after her house and children, and as she expressed it herself, never seemed tired.

When questioned as to when the illness actually began the patient dated the onset as beginning on October 6th, when she had a tooth extracted. She experienced some pain, and soreness of the jaw. To relieve this, unbeknown to her husband, she took twelve cincophen tablets, each of which contained seven and one-half grains. She repeatedly denied having taken more than twelve tablets, and thought that ten was more nearly the correct number.

Weakness increased until she was obliged to lie down after doing a little work. The smallest

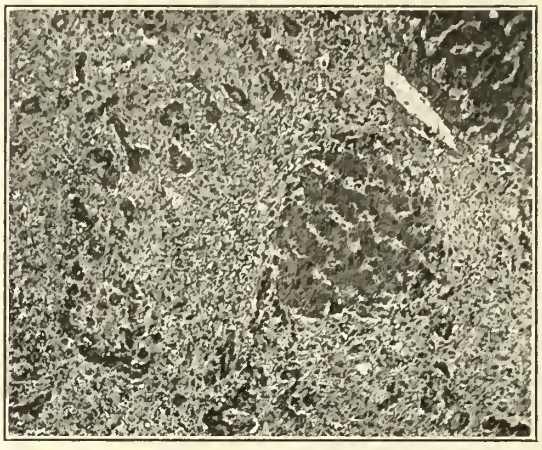


Fig. 1. Acute necrosis of parenchyma, foci of free hemorrhage, periportal fibrosis, regeneration of bile ducts.

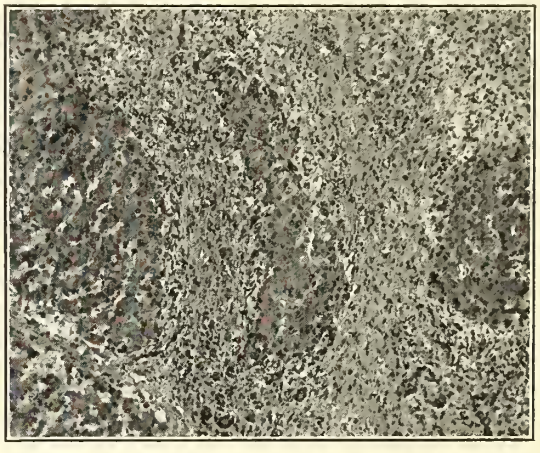


Fig. 2. Scantily cellular fibrous tissue in periportal zones.

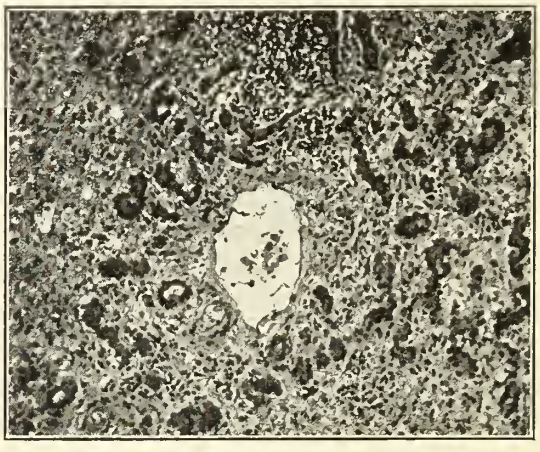


Fig. 3. Necrosis of parenchyma, large foci of round cell infiltration, regeneration of bile ducts.

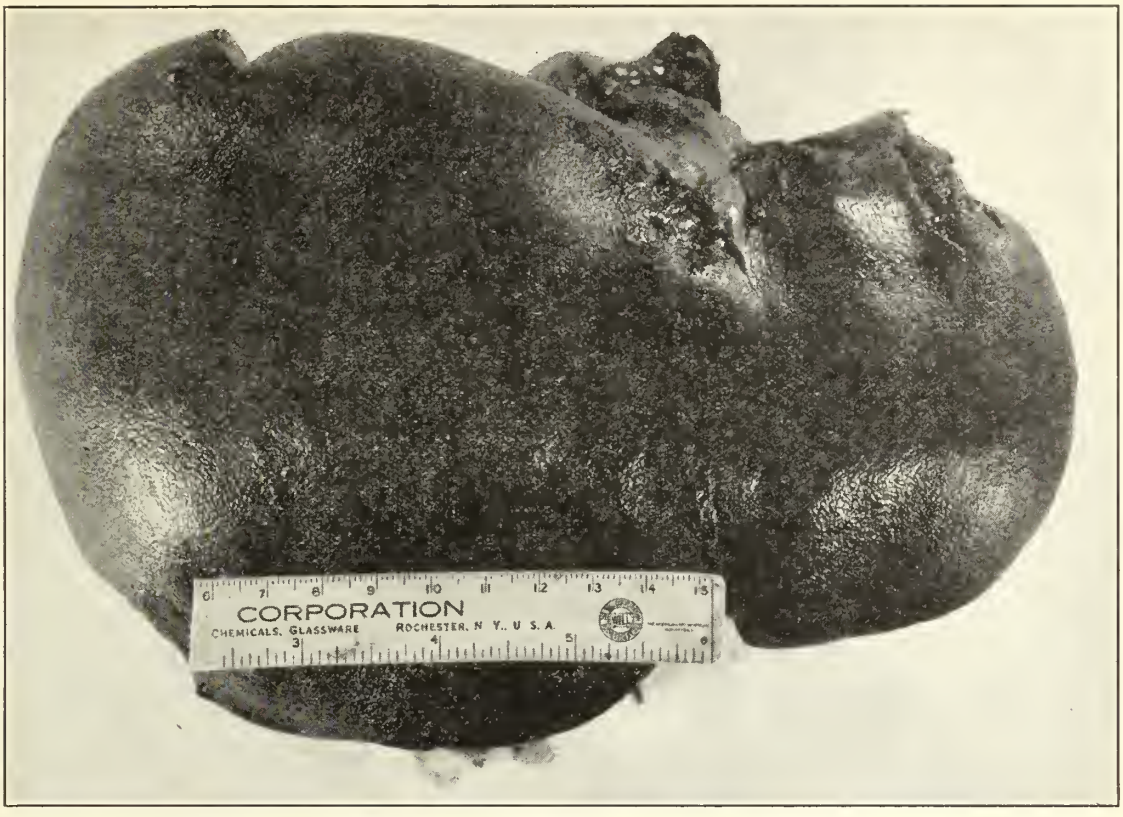


Fig. 4. Photograph made immediately after removal of the liver. Note the marked wrinkling of capsule and the general diminution in size.

task tired her. The sclerae became icteric about a week before I saw her, and jaundice gradually increased until by November 26, the skin was a faint yellow color. Constipation had become more obstinate, yet the stools were pigmented. There was no itching of the skin.

Physical examination disclosed the following essentials: Definite icterus was noted. The tongue was coated. The pulse rate was 110 per minute, while the blood pressure was 120 over 75. Temperature, 98. The abdomen was somewhat distended, and slightly tender to pressure, but not particularly tender over the upper right quadrant. The lower border of the liver reached to within one and a half fingers' breadth of the costal border. The spleen was just palpable.

The patient was immediately transferred to the Deaconess Hospital. The disease progressed with an occasional day of seeming improvement until death occurred one month after admission. The patient remained conscious and rational until the last four days. She suffered extreme abdominal pain at various times, especially at night, and required morphine for relief. The bowels were obstinately constipated, but the stool was always colored. Abdominal distention became marked soon after admission, and for most of the time equalled the size of the abdomen of a woman in the eighth month of pregnancy. This distention was due in part to ascites, and in part to gaseous distention of the intestines. Paracentisis was done on three separate occasions, but the fluid returned within forty-eight hours. The character of the fluid is given in the accompanying table of laboratory findings. The degree of icterus varied, but was never of an intense grade. At times it was just discernible. Why the patient suffered such severe abdominal pain led to much discussion among the physicians in attendance. One staff surgeon thought that the distention explained the pain, yet after tapping the pain was even worse.

Laboratory Findings:

Urine Grants 1,006 to 1,024, Albumin absent at first; later present. Bile was always found. Blood cells and casts were not reported.

Blood	11-26-30	12-2-30	12-22-30	12-23-30
R.B.C.	4,200,000	4,000,000	3,400,000	3,680,000
W.B.C.	10,000	8,500	8,000	10,500
Hemglobin	80%	80%	65%	70%
Color Index	.9		.9	
Polyruc Neutros	71%	66%	72%	
Small Mononuclear	6%	7%	3%	
Large Mononuclear	13%	12%	7%	
Trausitinial	4%	7%	7%	
Eosinophil	1%	2%		
Basophil	1%	1%	1%	
Basket Cells	4%	5%	8%	

Faeces—Parasites -0 Ova -0 Blood-0

Blood Sugar—45 mgs. per hundred cc. on ad-

mission, 58 mgs. to 90 mgs. on other examinations. Urea Nitrogen 13 mgs. Creatinin 1.9 mgs. Higbest 18 mgs. Serum Albumen 3.2. Serum Globulin 1.5. Wassermann—Negative.
Abdominal Fluid

Dec. 4—5125 cc. Sp. Gr. 1010—clear
Bile reported neg. No cells found.

Dec. 16—3500 cc. Sp. Gr. 1008—clear
Bile reported neg. No cells.

Dec. 21—10,050 cc. Turbid Sp. Gr. 1008
Bile + Albumen +.++
Many cells, apparently immature leucocystes were found in this specimen.

The temperature was recorded as ranging from 37 to 37⅖ with a pulse rate of 80 to 90 until December, when it reached 37⅖ accompanied by a pulse rate of from 90 to 100. The temperature was 38 by December 9, while the pulse varied from 100 to 120. From December 14 to December 19 the temperature remained at 37 to 37⅖ and the pulse rate dropped to 90. During this period the patient appeared better and we optimistically entertained some hope for her recovery. However, a slight increase in temperature together with a rising pulse was noted on December 20, and continued until the end.

Autopsy was limited to the abdomen. The abdominal cavity contained 2500 cc. of the fluid described above. The intestines showed no pathology. The uterus and adnexa were not remarkable. There was no evidence of pregnancy.

The liver weighed 750 gms., and was reduced to approximately one-third of the average size liver. Its appearance is shown in the illustration. The spleen weighed 25 gms. Section of the liver were sent to Dr. A. S. Warthin who reported as follows:

Mrs. M., patient of Dr. Lind. Advanced cirrhosis of the liver of the interlobular type marked reparative regeneration of small bile ducts and liver lobules. Icterus. Fatty infilteration around the periphery of many of the lobules. In many areas there is complete destruction of the liver cells with regeneration from new bile ducts, suggesting repair following acute yellow atrophy or some marked toxic necrosis of the liver lobules as chloroform or arsenic liver.

A detailed history of the patient was sent and Dr. Warthin replied that the microscopic sections of the liver tissue were characteristic and that they were identical with sections from the liver of known cases of cincophen poisoning. He recommended that a report of this case should be published.

The course of the disease differed somewhat from the usual. Our patient lived longer than most. She had more pain than any other case observed by any of the physicians in attendance. Ascites does occur in acute yellow atrophy of the liver, but is uncommon. We may theorize that this woman lived long enough to have sufficient firm fibrous tissue deposited about the portal radicals to cause stasis. However, none of the superfical abdominal veins were enlarged. No one offered any explanation as to why the fluid reaccumulated so rapidly after tapping, nor why the patient had such intense abdominal pain.

MEDICAL ARTS BLDG.

Psychoneuroses Observed Among Ex-Soldiers

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IN psychoneuroses among ex-soldiers the same factors or mechanisms were observed as in other psychoneuroses. They were found principally in those men who had failed in effecting an adequate adjustment to their environment, who possessed an inferiority complex, and persisted in infantile ways of thinking, or in those who were susceptible to suggestion. In these were observed the same mental complexes and conflicts as in other cases. They differed from them in that the mental conflicts were not often observed to be of a sexual nature. In all these cases, fear with worry was the main factor.

They were classified mainly as neurasthenia, psychasthenia, anxiety neurosis and hysteria. Many appeared true to type, but there were a number in which the types were not sharply defined, and which showed combinations of different types. There were also those which were present with, or secondary to, organic conditions, and these were classified as psychoneurosis with, or secondary to, organic conditions. They were found present with tuberculosis, heart disease, syphilis, pyorrhoea, sinus disease, arthritis, appendicitis, ulcer of stomach, etc. It appeared that the symptoms or sensations due to the organic condition and which were not understood by the patient caused a fear or worry, which was the exciting cause of the psychoneurosis.

Of these the larger number, about 55 per cent, were classified as neurasthenia, about 20 per cent as psychasthenia and anxiety neurosis, and 25 per cent as hysteria. Among the neurasthenic types were the congenital and acquired forms. The history of congenital types showed that in

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childhood they did not get along at school; that when called on to recite, they would blush, tremble and become confused, and often were affected with stammering and eneuresis. Many of these men, when not subjected to any great physical or mental stress, got along fairly well but soon after entering camp, when they came in competition with others who were superior in intelligence or mental stability, their condition became aggravated. This class persisted in infantile ways of thinking and when problems arose, they were not able to cope with them.

ACQUIRED TYPE OF NEURASTHENIA

Of the acquired type of neurasthenia, although a number gave a history of previous neurotic symptoms, there were a large number in which no such history was obtained. Many cases were observed during the war in which the condition appeared to be due to simple mental fatigue due to long hours of work with great mental or physical strain, but among such were a number who assumed responsibilities greater than in civil life, and in these cases there was the worry because of a feeling of inadequacy, added to which was the humiliation of finding himself outstripped by his fellows. Many men after a rest in hospital or convalescent camp, or with a change of surroundings, improved or made a good recovery.

There was another class that appeared to get along fairly well until put under some severe mental or physical strain, when they developed neurotic symptoms. In this type it appeared that the determining factor was the soldier's mental stability, that the person who possessed a good mental stability could stand almost any stress, but that there is a limit to the stress that any one can stand, and when that limit is reached, one is liable to develop neurotic symptoms.

An example of wonderful mental stability was seen in a soldier examined on account of an organic condition. This man was knocked unconscious several times, was gassed and had fifteen scars from shrapnel wounds over his body and limbs, only one of which caused any serious organic trouble, a muscular spiral paralysis, on account of which he was examined. He was of a cheerful disposition, was satisfied he had done his duty, and was grateful to the Government for obtaining a job for him as a rural mail carrier. On examination no evidence of any neurotic condition could be detected.

Among the acquired types of neurasthenia, were a large number who developed symptoms after being gassed, knocked down, or knocked unconscious by a nearby shell explosion. Following the trauma, they developed the psychasthenic type of neurosis (fear or phobias). Many of these later apparently overcame their fears, but most of them then developed true neurasthenic symptoms. A number of cases were examined several years later and although they appeared to have adapted themselves, showed evidence of their condition by tremors, vasomotor changes and exaggerated reflexes. In some instances it appeared that the concussion left some residual to account for the symptoms.

A number were classed as anxiety neuroses who showed a worry or anxiety about some somatic complaint. The hysterical types were found mainly in those whose mentality was below the average, although a small number were found in those whose mentality was above the average. This type was observed in two classes:

1. Those in which the individual received the wrong impression or suggestion, and believed he was seriously injured.

2. Those in which some wish was unrecognized or could not be fulfilled, and the neurosis is the spontaneous expression of the tendency towards the fulfillment of the wish.

Under number one, wrong suggestions, were a number of cases in which the physician himself gave the wrong suggestion or impression to the patient. An example of this was seen in a soldier who at camp while making a broad-jump, felt something snap in his back after which he lost power in his right leg. He was taken to the hospital and while there heard his case discussed as a spinal cord injury, and shortly afterwards was discharged from the hospital with no explanation. I saw this man four years later, at which time he had a marked atrophy of the right thigh and leg, a large hysterical foot, a complete paralysis of all muscles below the right knee, with a complete anesthesia from a sharply defined line at the level of the upper part of the right patellar down over entire leg and foot, with equal and exaggerated patellar reflexes. At that time he was using a crutch, dragging his lower right limb. He was offered hospitalization which he refused. When he was given a placebo with the suggestion that his case was understood, and he would recover; he was told to take his medicine (placebo) as directed, to use a small battery which he had, to massage his leg and to use it. Eight months later, he walked into my office without support and at that time had entirely recovered from his hysterical foot, and from paralysis and sensory disturbances. He was put in placement training which was successful. This case was followed for two years, at the end of which period there was no evidence of a return of symptoms.

There were a number of men who developed hysterical symptoms after typhoid inoculations. Some of these from auto-suggestion developed pains in arms and neck and several developed stammering and spasmodic torticollis. Many of the cases observed were caused or aggravated by suggestions received later from various physicians, osteopaths or chiropractors. They were led to believe that they were seriously injured and that a nerve had been injured by the inoculation. Affidavits were sent in from physicians stating

that the patient was suffering from a neuritis following inoculation. Several cases of spasmodic torticollis with proper suggestive treatment, or a short stay in Government hospitals made a good recovery.

A number of cases after receiving superficial gun-shot wounds of arms or legs developed hysterical paralysis or anesthesias, and some who in addition to an organic paralysis developed hysterical paralysis or anesthesias.

Under number two, wish fullfilling desires, were several similar to the history of the soldier who was to be sent to the first-line trenches the following day, and who developed a wish or desire that something would happen to him to prevent his being sent forward, and who the next day developed an hysterical paralysis of the leg. The part suggestion played was noted in the large number of soldiers whose complaint was flat feet. In not only the hysterical but in other types suggestion played an important part.

A wrong suggestion was seen in the case of a soldier who while under shell fire lay with face to the ground behind a tree, which was shortly afterwards struck by an exploding shell, falling across his back. At the time he suffered from a slight bruise of back and was sent to convalescent camp from which he was shortly discharged and sent back to duty. After discharge from the army he worked at his trade for several years, when one day he consulted a physician who ordered an *X*-ray made of the spine which showed a faint line, like a pin scratch, across transverse process of a lumbar vertebra. I examined this man soon after he had seen this *X*-ray picture, at which time he was completely discouraged. He said his back was broken, that he was totally disabled and could never work again. It was only after many months that he could be convinced of his ability to do any work.

A case of wrong suggestion was seen in a young ex-soldier who was much worried because of supposed organic heart disease. He had done no work for several years, and had received treatment from a number of doctors and chiropractors, one of whom had told him that he had valvular heart disease and should never overexert himself. At the time he was taking a number of drugs, was on a special diet, and was prohibited from smoking or indulging in any exercise. In addition to other neurotic symptoms, he showed a tachycardia which could be accounted for by his nervous condition. Examination showed no other evidence of heart disease. He was assured that he had no heart disease and was told to eat what he liked and to indulge in what sports he cared for, and was given a placebo in the form of a mild sedative. When examined six months later, he said that shortly after taking the medicine given him, he noticed an improvement and two months later went to work and felt that he had recovered. At that time his pulse rate was normal, and with the exception of a slight increase in reflexes he showed no evidence of his former trouble.

The part suggestion played was seen in a number of so-called "pension neuroses." In these cases the soldier worked steadily for a year or two after discharge from the army, when it was suggested to him that he had a disability and was entitled to hospital care and compensation. A number of these who after being examined did not receive the treatment expected, or the amount of compensation to which they thought they were entitled, were never able to adjust themselves properly and have made no attempt to work, or have done very little since.

Several cases were seen in which an organic condition was present and not recognized, all the subjective symptoms being attributed to the psychoneurosis, one being a severe case of hysteria with a duodenal ulcer which was not recognized until the patient had a perforation from the ulcer.

TREATMENT

Due to repeated examinations the results of treatment were observed in most cases. Those soldiers in whom any organic condition if present was treated or removed, and in whom the personality was treated by proper psychotherapy, including explanation, persuasion and suggestion, and who were able to adapt themselves, showed improvement or made good recoveries. However, there were some who in spite of all proper psychotherapy were never able to adjust themselves and when examined several years later the same conditions were found. These could not be handled like cases in civil practice. It was necessary to give them compensation in the form of monthly payment and no settlement could be made. The fact that they reecived compensation would tend to convince some that they had a serious condition, while others felt that they did not receive the amount to which they were entitled.

HOSPITALIZATION

Many cases were benefited by hospitalization, where an organic condition if present was treated or removed, where proper explanations and suggestions were made, and where they were shown how to adapt themselves to their environment. But there were many more instances in which hospitalization was not only of no benefit, but tended to aggravate the condition, in which it was for the time being a way of solving the man's problems or difficulties, where he could receive the attention he demanded with full compensation and when such attention and compensation was not received, his condition became aggravated and further hospitalization was demanded.

A case of hysteria with convulsive seizures following appendectomy had at one time received total compensation and could not understand why he should not always receive it. He had been

treated in various hospitals but could not be convinced that he was not totally disabled. This man was seen at different times by members of numerous organizations who demanded that he receive hospital care, and during several years he had been at one time or another in most of the Government's hospitals. Shortly after entering the hospital, and for a time subsequent to leaving, while receiving the maximum amount of compensation, he showed few if any symptoms. However, as soon as he was examined and compensation reduced to the amount to which he was entitled, he became irritable, his condition became aggravated, and he would again have convulsive seizures. Then he would again be seen by someone who would demand that he be sent to a hospital. This was repeated until he was finally made to understand that he would receive no more hospitalization, and that there would be no change in his compensation. He then adjusted himself and went to work, and has been working regularly since that time.

VOCATIONAL TRAINING

Shortly after the war, most soldiers who showed a disability, and providing such disability would permit, were given vocational or placement training. The psychoneurotics were given the same opportunity. Those cases in which the personality was treated and in which the men were able to adjust themselves to their environment were benefited by such training, but many were put in training without regard to their personality, or the training for which they were fitted. being given the training they desired, and before attempting by proper psychotherapy to have them adapt themselves. A large number were unable to so adapt themselves, and consequently were transferred from one kind of training to another with no success. For this reason it later became almost impossible to secure training for cases of this type.

A small number who were able to adapt themselves and who were placed in training for which they were fitted, were much benefited by vocational and placement training. Of the different types the hysterical as a rule showed better results than the neurasthenic or psychasthenic types, and many of these have since followed the vocation in which they were trained.

SUMMARY

In psychoneuroses occurring among ex-soldiers, fear with worry was the main factor and occurred mainly in those men with poor mental stability, who failed in effecting an adequate adjustment to their environment, who possessed an inferiority complex and persisted in infantile ways of thinking, or were easily susceptible to suggestion. In those cases in which the fear with worry was removed, in which the personality was treated by proper explanation, persuasion and suggestion, and where the men were made to see how they could readjust themselves to their environment, the results were good, and they were benefited by vocational or placement training. But in the cases where the men could not adapt themselves or could not be shown how to do so, the results were not beneficial.

340 NICHOLAS BLDG.

Cranial Cerebral Injuries

JOHN DICKENSON, M.D., F.A.C.S., Cleveland, Ohio

CRANIO-CEREBRAL injuries are among the most common and important injuries in traumatic surgery today. The ever increasing number of auto vehicles, the more improved highways allowing greater speed, driving into sections where railway crossings are still unguarded, together with the growing number of aeroplane accidents, are factors that are more and more compelling our attention to this type of surgery. These injuries should entertain our keenest interest because they are not found entirely in the large hospitals of our cities, but are almost daily entering the smaller hospitals of the country districts, many of them occurring in the residential and rural communities.

It is not my purpose to make a statistical study of these cranio-cerebral injuries; however, an investigation and review of reports from many hospitals show that about 75 per cent of cases are due to automobile accidents, falls being responsible for the next larger number, about 18 per cent. The analysis further indicates that the average mortality varies from 28 to 35 per cent.

At Charity Hospital, Cleveland, in the past three years we have had 214 cases of cranio-cerebral injuries, 87 per cent of them due to automobile accidents. Forty-four cases died—a mortality of 21 per cent. Thirty-six cases or 17 per cent died within the first 24 hours, and eight cases or 4 per cent died between 24 hours and 12 days. Five of these cases had injuries other than cranio-cerebral, but the latter was the more serious injury. Radiographs of the skull were not taken in 38 cases on account of their serious condition, of the remaining 176 cases where radiographs were taken, 122 showed positive *X*-ray findings, 88 of the vault, 34 of the base, and eight cases showed fractures of both vault and base. Fifty-four cases gave negative findings but all had positive signs of an intracranial injury. Surgical intervention was required in eight cases,

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two for extradural hemorrhage, one decompressive operation, and five for decompressed fracture (three of which were compound), with one death from meningitis.

Dr. Edson Brown of St. Luke's Hospital, Cleveland, reports 343 cases in the last five years, with 102 deaths or a mortality of 29.73 per cent. Seventy-four cases out of the 102 died in less than 24 hours; 72.3 per cent of his cases were due to motor cars; 31.48 per cent were children less than 12 years of age.

CLASSIFICATION

Numerous classifications of brain injuries have been given in medical literature, but most of them are only of value from a theoretical satndpoint. More recently a classification of injuries of the brain based upon cerebral spinal fluid pressure alone, as shown by the mercury manometer, is held by such men as Rodman, Neubaurer, and Jackson, as superior to the accepted classification of concussion, contusion, and compression. In traumatic surgery there are only two types of craniocerebral injury, those that should be operated upon, and those that should not be operated upon. Our early efforts should be directed to placing our cases in one of these classes, but this can not always be done immediately.

Brain injuries that should be operated fall into three classes, and are:

1. Middle meningeal hemorrhage.
2. Simple or compound fracture with bone pressure or bone fragments in the brain.
3. Cases in which there is a rapid increase in intracranial pressure not amenable to other forms of treatment.

Extradural hemorrhage is one type of injury of the head that stands out alone in demanding prompt and effective operative treatment. The actual percentage of this type of injury is small, perhaps 5 per cent. If recognized and treated correctly nearly all can be saved. Nearly all will be lost if left untreated or treated badly.

Extradural hemorrhage is caused by the line of fracture crossing and tearing the middle meningeal artery in the temporal region. The hemorrhage develops steadily and quickly, as it progresses the dura is stripped from the skull thus producing many additional bleeding points where branches of the artery cross from the dura to the skull.

It is very difficult at times to tell when you have an extradural hemorrhage, but it may be suspected from three symptoms:

1. A free interval of consciousness before a gradual deepening coma. (Due to intracranial pressure).

2. Gradual hemiplegia, affecting the face, arm and leg, in the order mentioned.

3. Convulsions, beginning always in the face and spreading to the arm and leg. All of these signs may be absent, and all may be present in primary injury of the brain.

There is only one treatment for the extradural hemorrhage, and that is to remove the clot and tie the middle meningeal artery.

Simple or compound fracture with bone pressure or bone fragments should be operated. A careful search should be made for fragments penetrating the brain. Frequently fragments are overlooked and are a cause of future trouble. If the patient's condition permits, good stereoscopic radiographs will disclose these fragments.

Extra-cranial injuries should be surgically cleansed with the same degree of thoroughness as if they were compound fractures extending into and involving the brain. Indeed, until the margins are separated, each wound must be regarded as potentially a compound fracture. It should not be examined until preparation is complete. The torn surfaces should be protected while the sursounding area is being shaved and cleansed. The improper handling and examination of wounds is their greatest source of contamination. As haemostasis is being secured, the involved layers of the scalp should be noted and cranial involvement determined. The surface of the skull should be carefully examined for evidences of depression or linear fracture.

Simple scalp wounds, when properly prepared, can be safely sutured without drainage; however, they must be inspected frequently. The occasional infected wound can be drained easily by spreading the margins after removal of a suture. One must be on the alert for burrowing infection in the dangerous area of the scalp, and if this is encountered it must of course be dealt with promptly and freely. Haematoma of the scalp offer little resistance and disappear quickly with the application of pressure dressings.

Simple depressed fracture, I believe, need not be considered as an emergency operation. The general condition of the patient should be dealt with and sufficient time allowed to elapse so that the patient may recover from shock.

It does not matter whether we classify fractures of the skull into the two types—base and vault. Either type may be equally serious. It is much better to consider the problem of saving life. However, basal fractures are responsible for by far the greatest number of deaths from injury to the head. These fractures are due to indirect violence in the nature of a counter stroke. There is always some laceration and hemorrhage and the most vital areas of the brain are involved. Early prognosis depends upon the extent of brain injury and the presence of edema. Later prognosis must be equally guarded because of the possibility of infection, for basal fractures are usually compound and may extend into fields potentially septic.

As a matter of fact we are relatively little concerned with the actual fractures of the skull. In this respect fractures of the skull are entirely different in significance from all of the other bony

fractures of the body. It is the injury to the intracranial contents which is all important. Patients do not die from fractures of the skull, they die from injury to the brain. Patients do not have epilepsy from the injury to the skull, they have epilepsy from injury to the brain. Far too much is the treatment of today directed to the fracture of the skull itself, especially linear fractures. It would seem it is difficult to leave tradition and to work rather upon an anatomic physiologic, and pathologic basis. Although these facts are slowly manifesting themselves, it requires time to change.

All cases in which there is a steady, increasing intracranial pressure, or a persistent high pressure that is not amenable to medical treatment, should receive a sub-temporal decompression.

NON-OPERATIVE CASES

Brain injuries that should not be operated are:

1. Extensive brain injury with laceration and separation.
2. Injury in which there is no primary increase in intracranial pressure, but which usually develops later due to an accumulation of fluid and edema.

Included in this class are simple non-depressing fractures and so-called cases of concussion. Injuries in which there are extensive lacerations and cellular separations reach a rapid stage of exhaustion and medullary paralysis. These massive types of brain injury are fatal and no treatment is of benefit. They pass rapidly into coma and death soon ensues.

The second type under this classification fortunately is the more common and encouraging type of injury so far as treatment and prognosis is concerned, seldom (if ever) is an operation indicated. The case presents a dazed or semi-conscious condition. There is no marked shock, blood and spinal pressures are normal or slightly raised. Radiographs reveal nothing, or possibly a slight linear fracture. The eye grounds are negative. The pulse and respiration are normal. There is a picture of definite brain injury with no indication for surgical intervention. You have all seen these cases and know that, within twenty-four or thirty-six hours, the majority will *show* symptoms of delayed or secondary increased intracranial pressure, characterized by a slowly increasing pressure, decrease in pulse rate, increase in temperature and restlessness, and approaching coma. These cases are usually responsive to proper treatment.

When the skull is traumatized, the brain is injured because it is thrown against the sides of the skull. The resultant injury produces, within the brain, changes which are precisely the same as those which appear in the tissues elsewhere when injured. Therefore, the swelling is the result of two components—hemorrhage and edema, and these occur in different proportions; sometimes the hemorrhage predominates, at other times the swelling is largely fluid. Intracranial pressure in these cases results from hemorrhage and edema. It is this intracranial pressure that is all impotrant in cranial cerebral injuries, causing interference with the paths of absorption and circulation of the cerebral spinal fluid. If not relieved early, the increased pressure leads to chronic morbid changes in the cortex of the brain or, in extreme cases, to death.

Two cardinal facts about the skull and its contents form a basis of a true understanding of the pathology of the intracranial pressure. The skull in the adult is a rigid case which is incapable of expansion and the total volume of the intracranial contents is therefore constant. These contents may be, for practical purposes, regarded as three—the brain, the cerebral spinal fluid, and the blood vessels. Since their total volume is constant, an increase in the volume of any one of them can only occur at the expense of the volume of one or both of the others. For example, if the brain becomes enlarged by the growth of a tumor, there must necessarily be a corresponding decrease in the volume of the blood or the cerebral spinal fluid or of both. Such adjustments can only occur to a very limited extent without raising the intracranial pressure. The most obvious way to reduce raised intracranial pressure is to abolish in part the rigidity of the skull, i.e. to perform a decompressive operation. This was, until recently, the only method available, and it is still the method of election in certain circumstances. There are, however, a number of conditions associated with increased intracranial pressure, in the treatment of which such a serious operation is unjustifiable, and others again in which it is to be avoided if possible.

In order to understand the newer methods of treatment and the advantages that may be gained by their use, it is essential that the surgeon should have at least a workable knowledge of the anatomy and physiology of the cerebral spinal water-bed.

As this subject is such a vast one, I shall confine my remarks briefly to a few practical points. The cerebral spinal fluid is probably secreted in the ventricles by the choroid plexus. The lateral ventricles normally contain about thirty cubic centimeters. The fluid finds its way from the lateral ventricles through the foramina of Monro to the third ventricle, thence along the aqueduct of Sylvius to the fourth ventricle. In the roof of the fourth ventricle, posterially, is the foramen of Majendie, and in each lateral recess the foramen of Luschka through which the fluid escapes to the large cisterns beneath the arachnoid. These cisterns contain normally about sixty cubic centimeters of fluid, but in pathological states may contain two or three times this amount. Another thirty to sixty cubic centimeters is present in the spinal portion. The fluid rises through the incisura tentorii to be distributed over the cortex

of the cerebrum. This is constantly being absorbed, mostly by the arachnoidal villi into the dural sinuses when there is no obstruction to its circulation. The total amount is renewed (as some believe), several times during the day, serving to dilute and carry off the metabolic waste products of the brain.

The cerebral and spinal subarchnoid systems are freely connected with each other, as was first demonstrated by Key and Retzius. This allows artificial drainage of the cerebral subarchnoid water-bed by the spinal route.

TREATMENT

For many years physicians have tried to develop a standardized treatment for injuries of the head. This is an utterly unattainable desire which, it stands to reason, can never be reached because these injuries are so tremendously variable in their results.

The treatment of cranial injuries the past century has been divided into two schools,—one school practicing and teaching that nearly all cases should be operated upon, the other school advising against operative treatment unless the fractures were compound or badly compressed. At the present time there still remains great differences of opinion. Some treat conservatively, others more radically. There have been many new additions to our methods of treatment, such as spinal drainage and hypertonic therapy, which have greatly lessened the number of operative cases in the last few years. The treatment of head injuries by hypertonic solutions is the rational use of methods which, in the form of free purgation, with calomel and salines, have been used empirically for many years.

LUMBAR PUNCTURE

Lumbar puncture is not only valuable as a diagnostic aid, but is a great therapeutic measure in relieving increased intracranial pressure. The use of the spinal mercury manometer is the only accurate method of estimating this pressure. Its use will guard against the withdrawal of too much fluid beyond the danger point. Counting the drops or estimating the rate of flow of the spinal fluid from the needle is not a safe guide. Lumbar puncture should be performed slowly and the pulse rate, respiration, color, and blood pressure should be noted. If blood is present in the fluid and the pressure is high, 10 to 20 cc. of fluid should be withdrawn deterring the fall in pressure by a special stop-cock arrangement of the needle attached to the mercury manometer, stopping the withdrawal of fluid when the pressure has been reduced one-half or to normal. The lumbar puncture can be repeated at intervals of six to 24 hours, or longer, depending on the height of pressure and the rapidity with which the pressure rises after withdrawal of the fluid. If the spinal fluid is bloody, it should be withdrawn daily until it becomes clear. Lumbar puncture is dangerous when the patient is in a state of shock, and when there is a block at the base and high pressure above. In the latter condition ventricular puncture is a safer method of drainage.

HYPERTONIC SOLUTIONS

To Week and McKibben has been given the credit of first demonstrating in 1919 that the intravenous injection of a hypertonic solution causes a shrinking of the brain and a fall in the pressure of the cerebral spinal fluid even to zero. Dorman in 1922 and Fay in 1924 advocated the use of hypertonic solutions in cases of acute intracranial hypertension resulting from cerebral trauma. Hypertonic solutions of sodium chloride, Ringers' formula, magnesium sulphate and dextrose are those commonly used at the present time. Sodium chloride, when introduced into the blood stream, raises the osmotic power of the blood so that there is a withdrawal of fluid from the tissue spaces, especially those of the ventricular system, and a re-absorption of part of the cerebral spinal fluid into the blood stream. This action is prompt, causes a shrinkage of the brain and a fall in the intracranial pressure. This effect is followed within one to two hours by a secondary edema of the tissues, and a rise of intracranial pressure, due to the fact that sodium chloride is dializable, and when present in high concentration in the blood, passes in variable amounts from the blood stream into the tissue spaces and is retained in them. When the concentration of the sodium chloride in the blood stream is reduced by renal excretion below that temporarily in excess in the tissues, the higher osmotic power of the tissues causes an excessive re-absorption of the fluid by them from the blood resulting in edema. This secondary edema is at times quite marked, and is a distinct disadvantage in the use of solutions of sodium chloride in those cases where prolonged treatment for the reduction of pressure and edema is necessary. Sodium chloride is best given intravenously. It is usually sufficient to give 70 to 100 cc. of a 15 per cent solution. This amount may be repeated every four to six hours. Care is necessary while injecting this solution that none escapes into the subcutaneous tissues for necrosis will result. Sachs has shown that there is no increase in the friability of the red blood cells after the use of solutions of this strength. Sodium chloride has been given by mouth and by rectum in hypertonic solutions. Given by these routes, its action is somewhat slower and less effective than when used intravenously, and is often followed by gastro-intestinal symptoms. Because sodium chloride is dializable it has a two-fold action when given by mouth or rectum. Some passes through the intestinal mucosa by osmosis into the blood stream and raises the osmotic power of the blood acting the same way as when given intra-

venously, while that remaining in the intestines abstracts fluid locally from the tissues. A secondary edema follows the use of sodium chloride when given in this manner just as after its intravenous administration.

Ringer's Solution.—This solution is given intravenously in the same quantities as sodium chloride solution and is equally effective. Its primary dehydrating action is also followed by a secondary edema similar to that occurring after the injections of hypertonic sodium chloride solutions.

Magnesium Sulphate is administered by mouth and rectum—never intravenously because of the danger of a general anesthetic effect and respiratory paralysis. Although its action is not prompt as that of sodium chloride, Fay considers it more efficacious and this salt possesses the decided advantage over sodium chloride of not producing a secondary edema of the tissues. As magnesium sulphate is not dializable it cannot pass through the intestinal mucosa into the blood stream unless the mucosa has been severely damaged. It acts by dehydrating the blood in the intestinal capillary network thus raising the osmotic power of the blood which then depletes the tissue spaces throughout the body. Magnesium sulphate is given by mouth in doses of 60 c.c. of the saturated solution repeated every four to six hours until the desired degree of dehydration is obtained. A mild continuous action is obtained by administering 15 to 30 c.c. of the saturated solution every two to three hours or twice that dose by rectum. One dose of 60 cc. is sufficient in those cases of mild trauma which complain only of headache.

Rectal administration is the most satisfactory method of using this salt. It is effective, the patient is spared the discomfort of active catharsis, and the method is applicable in the presence of vomiting as well as when the patient is unconscious or non-cooperative. The dose is 90 gm. dissolved in 175 cc. of water, introduced slowly through a rectal tube and repeated every four to six hours. The effect is noticeable in about one hour. If a larger amount of water is used the patient may have difficulty in retaining the solution. Unless retained for one-half hour the injection will not produce its full effect, and should be repeated one hour later. If the rectum is irritable, retention of the solution is aided by adding to it 4 cc. of camphorated tincture of opium. The fluid abstracted from the tissues by the magnesium sulphate accumulates in the rectum and can be siphoned off intermittently by means of a rectal tube.

Dextrose is probably the most useful of the hypertonic solutions. When given intravenously it directly increases the osmotic power of the blood causing a fluid depletion of all tissue spaces. The action of glucose is slower and much more prolonged than that of either sodium chloride or magnesium sulphate. It does not dehydrate the body severely as do the other solutions. Its food value is important in cases requiring treatment as it assists in preventing acidosis, and it is of distinct value in relieving shock. The atcion of glucose can be further increased by the simultaneous administration of insulin.

Dextrose is given intravenously, 11 cc. to 200 cc. of a 25 to 50 per cent solution, repeated every eight to twelve hours. In urgent cases, when a more prompt action is required than can be obtained from glucose alone, it may be given in a 15 per cent sodium chloride solution, or the sodium chloride solution may be given first and followed within one hour by the glucose as suggested by McClure and Crawford. In this manner advantage is taken of the prompt action of sodium chloride while the glucose serves to prolong that action at the same time tending to prevent the onset of a secondary edema.

ADMINISTRATION

All intravenous injections of hypertonic solutions must be made slowly, not exceeding the rate of 3 cc. per minute, and while the injection is being made, the pulse must be carefully watched. Any sudden change in the rate or quality of the pulse is an indication to stop the injection which may be resumed after one or two minutes at a slower rate.

The fluid intake of the patient must be restricted, at least during the first 24 hours, but care is necessary to prevent over-dehydration. When the edema and pressure have been relieved, the hypertonic solution is continued over a period of seven to ten days, in gradually decreasing amounts.

When instituting treatment in cases of cranial trauma, it is important not to dehydrate further a patient whose circulatory system has already been depleted by shock or hemorrhage. Some degree of shock always accompanies cranial traumatism, and during shock dehydration is contraindicated. However, a dangerous degree of edema will but seldom develop until after the rise of the general blood pressure which takes place during recovery from shock. The onset of increased intracranial pressure is easily determined for shock is characterized by low blood pressure, low temperature, rapid pulse and respiration, while with increased intracranial pressure and medullary edema there is a gradual rise of the temperature above normal, an increasing blood pressure, the respiration becoming slow, the pulse slow and bounding, except when the edema has increased to a dangerous degree in which condition the pulse is rapid and thready similar to that of shock.

It is in the early treatment of traumatic cases that glucose is particularly valuable, for advantage can be taken of its power to combat shock as well as to prevent the onset of edema.

OVER-DEHYDRATION

A careful check should be kept of the fluid intake and output of patients being treated with hypertonic solutions and after the first 24 hours sufficient fluid given to effect almost a balance of the two. Fay reports two cases of over-dehydration. One came to autopsy and no fluid was found in the ventricular system. Shortly afterward he had another case, which developed symptoms resembling those of the first. Fluids were immediately pushed and the patient recovered. Fay gives as the diagnostic symptoms of over-dehydration, very rapid respiration, with air hunger, and a rapid, thready pulse, similar to that found after severe hemorrhage. There should be no difficulty in recognizing over-dehydration if the increasing respiratory rate is carefully watched for.

INDICATIONS

Like all other therapeutic procedures, the use of hypertonic solutions must be with an understanding of their limitations as well as their advantages, and in accordance with definite indications. It would be foolish to suppose that they can replace surgery in case of massive brain injury, in depressed and compound fracture, and where there is evidence of hemorrhage and localized pressure from the rupture of a large meningeal artery. Hypertonic solutions have, however, a very definite use as an adjunct to surgery, in these conditions,—to reduce intracranial pressure during, and lessen subsequent edema following operation.

The types of cases responding most satisfactorily to treatment, primarily with hypertonic solutions, are:

Simple non-depressed fractures of the vault, fractures of the base, and cases of "concussion" without fracture. These cases when seen early may have a normal or moderately increased temperature and blood pressure, normal respiration, moderate decrease in pulse rate, some congestion of the retinal veins on opthalmoscopic examination, and either partial or complete loss of consciousness. Frequently in cases of this type the surgeon hesitates to operate early, only to find in a few days a sudden and alarming cerebral edema demanding urgent and radical surgery. These cases, however, when treated from the beginning with hypertonic solution will usually show a rapid return of consciousness, a fall in spinal fluid pressure and a short, quiet convalescence with rarely any residual symptoms, such as headache, dizziness or change of temperament. Milder cases of concussion are relieved of symptoms much more quickly by this method of treatment than by the "expectant" form.

I believe that the use of hypertonic solutions in selected cases have greatly reduced the number of operative cases and the clinical results have been much better.

There can be no question but that a rational and valuable therapeutic procedure has been developed as the result of the work of Weed and McKibbon.

In many hospitals the treatment of these cases are sadly neglected. In others, I believe the pendulum has swung too far the other way, and patients are being early over-treated. In some institutions the following routine is carried out in every case regardless of the condition of the patient: They are immediately sent to the *X*-ray room for stereoscopic radiographs of the side of the head and the front of the head to determine the extent of the fracture, or if one exists. They are then usually transported to another part of the hospital for a lumbar puncture, the pressure of the cerebral spinal fluid accurately measured, and as much spinal cerebral fluid removed as possible. If the cerebral pressure registers high, the patient is immediately given an intravenous injection of hypertonic glucose or sodium chloride.

What is the urgent need of submitting these very ill patients to all this transportation and manipulation? Life itself is the paramount issue. As I said before, we should not be greatly concerned with the fracture itself at this time unless it be compound and pressing on the brain which condition can be determined by inspection and palpation. At this early stage of brain injury we as yet do not know what is going on within the cranium. Careful clinical observation will give us all the practical information needed at this time as regards intracranial pressure. If a hemorrhage is going on in the posterior cranial fossa, or an extradural hemorrhage is present, a lumbar puncture or the use of hypertonic solution may be dangerous at this time. The additional intracranial room acquired by the release of pressure allows the dura to be stripped still more and hemorrhage begins anew. I believe that very early spinal puncture should be reserved for that class of cases where a patient is picked up on the street in coma and remains unconscious with no obtainable history of injury, and where a positive diagnosis is impossible from other evidences. Then a spinal puncture is justifiable.

One can learn with fair accuracy by clinical observation the exact state of intracranial pressure. The state of consciousness is the most important observation. If a patient is unconscious we know that he has an intracranial pressure beyond the limit for compensation for consciousness. If the patient's coma deepens during the next five or six hours we know that intracranial pressure is increasing and that surgical intervention or some other means or method must be considered, depending upon the diagnosis. If the patient's consciousness is returning, that means that cerebral pressure is being reduced and the patient is improving. Spinal puncture may give a more scientific estimation of the degree of intracranial pressure, but it gives us no information of more

value than that given by the state of consciousness alone. The pulse and respirations should be taken every ten or fifteen minutes and charted in curves. As long as the increased cranial pressure is being compensated, the pulse, temperature, and respiration show characteristic changes. If the intracranial pressure increases beyond a certain degree, a break in compensation must occur and this is manifested by certain other characteristic changes. A slow pulse and slow respiration are indications of intracranial compensation. A temperature below 102 degrees is generally another valuable indication of the patient's safety. A broken compensation or an impending break in compensation is shown by vascillations in the rate of the pulse. It may be 90 one moment and 60 at another. Likewise the respirations become irregular in rate and volume and may be of the Cheyne-Stokes type. One very important and a most delicate index of intracranial pressure is the temperature. It is often one of the first and most positive signs that a break in compensation is developing. I believe when the temperature is steadily rising it is a positive sign that the intracranial pressure is becoming dangerously high.

If a patient is restless, he is on the border between compensation and a break in compensation of intracranial pressure. He is either coming out of coma or going into it. Therefore, restlessness should never be submerged by morphia, as this sign would be masked. Incontinence of urine and feces, occurring when the patient is seemingly conscious, means a break in cerebral compensation. These clinical signs should be carefully looked for and studied in every case of cerebral injury.

RATONAL TREATMENT

The rational treatment of these cases, I believe, consists first of a very careful examination of the scalp, ears, nose, mouth, pupils, and the body in general. As cranio-cerebral injuries are always attended by some shock the patient is placed at absolute rest, with the head and shoulders elevated, ice-cap to head. The patient is made warm by external applications. Large quantities of intravenous fluids are contra-indicated in combating this type of shock and should be withheld as a last resort. The only effort at diagnosis during this period is the half hour recording of pulse, respiration, temperature, and blood pressure. This is done without disturbance of the patient, and gives an index of the degree of shock.

A rising blood pressure and a slowing of the pulse rate is an indication of shock reaction at which time the study of the extent of the brain injury begins.

An attempt should then be made by careful observation and thought to classify the case as I have already mentioned. Many times this cannot be done immediately. However, until there is a definite indication to do something, the patient should be given the benefit of absolute rest.

Each case must be considered a law unto itself. As time goes on, and the patient shows signs that nature is unable to cope with the situation, the case having been classified as non-operative, the method of treatment must be left to the judgment of the individual surgeon, as to whether lumbar drainage or the use of hypertonic solutions or a combination of both should be resorted to.

Those cases that have a discharge of blood or spinal fluid from the ears, nose, or into mouth, should be given careful treatment as they may be portals of entry for micro-organisms, especially in cases of fracture of the base of the skull.

Elevation of the head and shoulders to almost a sitting position is important in the treatment of these cases. Hill states that any increase in the general venous pressure causes a slowing of cerebral blood flow. Wolf and Blumgart observed in animals that a definite slowing of the velocity of the intracranial blood flow resulted from elevation of the intracranial cerebral spinal fluid pressure. A rise in cerebral spinal pressure is accompanied by an increase in cerebral venous pressure because the skull is a closed cavity without elasticity. Therefore, the pressures of the cerebral spinal fluid and venous blood must closely approach each other, demonstrating that an increased general and cerebral venous pressure diminishes the cerebral capillary blood flow and favors stasis.

Blumgart showed by experiments that the upright position relieves the respiratory center of the increased pressure within the veins of that area in the following manner: There are no efficient valves in the veins between the cerebral capillaries and the right auricle. If a patient, with a venous pressure at the right auricle, equivalent to 15 cm. of water, lies flat in bed, there is a corresponding pressure of 15 cm. of water in the veins about the respiratory center. This results in diminished blood flow in the capillaries and stasis in this region. If, however, the patient sits up so that the respiratory center is 15 cm. above the right auricle, the pressure in the veins about the center is zero. The blood flow in the capillaries leading to these veins would then be increased. The respiratory center would receive a more adequate supply of blood and subjective respiratory distress would be greatly relieved.

Hill also found that the intracranial pressure of a patient who had been trephined was negative while the man sat upright but became positive as soon as the head was bent down towards the knee or placed in a recumbent position.

All these observations indicate that in man intracranial pressure and therefore cerebral venous pressure is diminished by changing from the recumbent to the sitting position. Further,

the upright position provides a certain amount of relief because it secures a lower position of the diaphragm and subsequent increased capacity of the thorax, thereby increasing the elastic tension of the lungs and so facilitating expiration.

AFTER CARE

There can be no hard and fast rule concerning the after care of these patients as each case presents a different problem. All cases should have absolute rest in bed from one to four weeks or longer and then gradually be permitted to be up and around during a period of from one to two weeks, and instructed to lead an easy life from one to two months longer. Most cases can return to light work in from one to three months after injury, and do regular heavy work after from one to three months more.

It is important that the diet be regulated and the fluid intake carefully limited throughout the period of convalescence. Sedatives such as barbital and luminal preparations, or other mild sedatives, may be necessary to relieve nervousness and insomnia. If headache, vertigo, or other unfavorable symptoms develop when the patient returns to work, a lumbar puncture may be indicated to ascertain the cerebrospinal pressure. If this pressure is high, another period of rest is needed and possibly spinal drainage or the use of hypertonic solutions until pressure returns to normal.

CONCLUSION

By way of conclusion I wish to emphasize that every case of cranio-cerebral injury is a law unto itself. Every case must have its individual study, and if possible be classified with every means at our command, and watched continuously until all danger is past. Only when we have determined what is taking place in the brain are we in a position to know what is best to do.

In properly selected cases, the judicious use of spinal drainage and hypertonic solutions will not only reduce mortality but will lessen the period of convalescence, and reduce to a minimum surgical intervention.

Lastly, we must guard against our treatments being overdone, with its resultant additional harm.

608 HANNA BLDG.

DISCUSSION

SIDNEY MCCURDY, M.D., Youngstown: I came prepared to discuss an ordinary paper on intracranial injuries, and not an exhaustive treatment of the subject as Dr. Dickinson has given.

There is no greater diagnostic puzzle offered than most cases of intra-cranial injuries. Great study must be used upon each case if a proper and adequate treatment is to be developed.

For me the practical classification is determined when I decide for or against operative treatment. Operation usually is associated with those cases which have to do with some compressive symptoms caused by active hemorrhage, results of hemorrhage, or by depressed bone or other foreign matter.

Where formerly operative treatment was common, it is now quite rare. Dr. Loyal Davis in a series of three hundred cases had to operate but four. The treatment of today seems to be one of combating shock, watchful waiting with extremely careful and painstaking observations, and the employment of dehydration with hypertonic solutions.

I feel that an accurate history coupled with careful observation will be very helpful in determining whether the patient is suffering from external violence causing damage to the brain, its blood supply, or its membranes.

A short period of observation will usually clear from the field of diagnosis, concussion and mild compression; neither of which require great treatment.

Morphine and atropine should be avoided during this period, since all pupillary and retinal symptoms may be obscured and much valuable clinical evidence lost. Some of the eye symptoms may be later manifestations yet the eye should always be explored. H. French says that contracted pupils bilaterally may indicate a pontine hemorrhage, which was again proved by an autopsy upon one of my recent cases.

I like to have the benefit of a Roentgenogram but would hesitate to jeopardize any patient to obtain it.

The relationship of blood pressure to pulse rate is very helpful in studying these cases and indicates pretty clearly what is happening within the skull. Fay thinks that the diastolic pressure is the most valuable reading since it registers the tension.

Some advise lumbar puncture at once and others wait a bit, for diagnostic purposes. All advocate the relief of signal fluid pressure if it is high, the amount varying according to height, and whether blood or pus is present in the fluid or not.

Hypertonic solutions of 50 per cent glucoses or dextroses, intra-venously, dehydrate promptly. In fact one has to watch for excessive dehydration. Magnesium sulphate per rectum may be added.

The bed should be really elevated at its head as intra-cranial pressure is reduced by such means. When a fair trial of dehydrating measures have failed, decompression must be resorted to.

I wish to thank Dr. Dickinson for what I have learned today from his thorough exposition of this subject.

Delegates from 26 professional fraternities attended a two-days meeting at Cincinnati, November 27 and 28, held under the auspices of the Professional Interfraternity Conference. Problems affecting the various professions generally were discussed. Medical fraternities represented at the meeting were Alpha Kappa Kappa, Omega Upsilon Phi, Phi Delta Epsilon, Phi Rho Sigma and Theta Kappa Psi. Among those who addressed the meeting were Dr. A. C. Bachmeyer, dean of the College of Medicine, University of Cincinnati, and Dr. Stuart Graves, Tuscaloosa, Alabama.

The Ohio-Pennsylvania-West Virginia sectional meeting of the American College of Surgeons will be held at the William Penn Hotel, Pittsburgh, January 25 and 26.

The President's Page

A Personal Communication to the Membership from

D. C. Houser, M.D., Urbana, Ohio

Most of the physicians throughout the state take advantage of all the newer methods of treatment and diagnosis and are, no doubt, rendering more efficient services to their patients than ever before in the history of medicine. This is as it should be, as many discoveries and inventions which are very valuable to the medical profession have been made in the last few years, and I know of no other profession that is more anxious to seek for the latest and most improved methods of help and assistance.

We have been trained to treat the sick and it is somewhat difficult for us to realize that preventive medicine is here; that the public is immensely interested, especially in that phase of preventive medicine which calls for periodic examinations of the apparently healthy, as well as the sick, and that if we, as family physicians, do not make these examinations they will go elsewhere.

The following quotation is from a letter which was sent to the Secretaries of the County Medical Societies and Academies of Medicine by the Periodic Health Examinations Committee:

"Great opportunities are being overlooked by many physicians in the field of preventive medicine, the committee believes. Scores of physicians, busy with the acutely ill, are not taking more than a casual interest in examining the supposedly well, thereby missing a chance to render additional service to their patients and at the same time losing an opportunity to extend their practice and enlarge their incomes. The layman looks to his family physician for advice on preventive, as well as curative medicine, so it is vitally important that every doctor, general practitioner, or specialist, accept this role of health counselor. It is imperative that we adjust ourselves to changing conditions. It is our duty to assist in awakening the community to its opportunities for better health, better living and the elimination of needless suffering, sickness, and resultant economic distress."

The Periodic Health Examinations Committee is willing and anxious to help in this great work and solicit your co-operation. Are we going to allow insurance companies and various other agencies to make these examinations and perform the numerous other services arising from day to day in preventive medicine? Medical organization is yet in a position to do the directing in preventive medicine, but if we fail to take advantage of our opportunities, public sentiment may become aroused and find a way to get what it needs in the way of Periodic Health Examinations.

Organized medicine must mould public opinion or be moulded and led by it. I can see no good reason why the medical profession should not inform the public of what it has done and is doing in preventive medicine and public health. Wise leadership by organized medicine in the solution of public health problems and public welfare needs was never more imperative than today.

Noise Detrimental to Hospital Patients, According to N. Y. Report

Noises in the vicinity of 80 per cent of the hospitals of New York City are harmful enough to retard appreciably the recovery of patients, according to a report recently prepared for the Noise Abatement Commission of that city.

It is recommended in the report that the law requiring silence on hospital streets should put a complete stop to traffic noise and should be used by the police in arresting unnecessarily noisy trucks passing through these streets. Many hospital superintendents requested that trucking be routed away from streets adjoining their institutions. New signs, demanding silence, also were requested. It is recomended further that patrolmen be stationed at hospitals to see that children playing nearby are sent to playgrounds. Fire apparatus should avoid hospital streets as much as possible. Noisy animals should be abated by the Health Department under the Sanitary Code, while doormen's whistles and peddlers should be stopped under the hospital street ordinance. Other noises complained of should be similarly cared for.

In conducting the survey, a group of questions was drawn up and sent to the superintendents of all hospitals in the greater city. Seventy-nine replies were received, 42 from Manhattan, 24 from Brooklyn, eight from the Bronx and five from Queens.

The first question was "Does any noise condition or conditions in the vicinity of your hospital retard appreciably the recovery of your patients?" Of the 69 superintendents answering this qustion, 55 replied in the affirmative and only 14 in the negative. In Manhattan 30 superintendents said yes and six no; in Brooklyn 20 yes and three no; in the Bronx three yes and three no; and in Queens two yes and two no.

The second question asked whether the effect on the patients was "serious, important or annoying." Thirty-four superintendents considered the noises so grave a menace that it seriously injured the patients; 20 thought it "important;" 17 annoying; and seven found that the noise around their hospitals did not affect the patients at all.

Exactly half the hospitals in Manhattan and Brooklyn reported that their local noise conditions were a serious deterrent to the recovery of their patients. None of the hospitals in Queens are faced with a serious noise menace and only one out of the eight in the Bronx. The figures were as follows:

Manhattan: serious, 21; important, 11; annoying, eight; no effect, two. Brooklyn: serious, 12; important five; annoying, four; no effect, three. The Bronx: serious, one; important, two; annoying, three; no effect, one; no answer, one. Queens: important, two; annoying, two; no effect, one.

These figures indicate an extremely grave situation of emergency, which must be immediately remedied as far as is possible under present laws by the agencies in whose hands is the enforcing of these laws. One of the most vital functions of any city is to take adequate care of its sick. It is essential that hospitals be surrounded with almost perfect conditions of silence. How far conditions are from perfect is startlingly indicated by the figures quoted above.

Many of the superintendents pointed out that the noise conditions not only had a detrimental effect but also interferred with the health and efficiency of doctors and nurses, thus making them less able to give the patients the best possible care. As has been shown by pervious studies made by the Commission, noise that has a serious effect on the sick has a detrimental effect on the healthy also. Many well people will be forced into hospitals by the same noise that will hinder their recovery when in institutions. The situation, then, is not only grave for those already sick.

The superintendents were asked what they specifically felt to be the effect of the noise on their patients. Although a large number did not answer this question, those who did said for the most part that it disturbed their rest and had a generally bad effect on their nervous systems.

The superintendents were asked to classify the noises around their hospitals into those that had a "vital" effect on the patients and those that although significant could not be described as vital.

Among the "vital noises" traffic was by far the most important, since 50 out of the 79 superintendents listed it. Heavy trucking was complained of 39 times, much more often than any other individual nuisance. Passenger cars and unnecessarily blown horns each received nine complaints; motorcycles, five; and buses four.

Traffic noises also led the "significant noises," there being 23 complaints, 16 concerning horns and 11 concerning heavy trucking. Thus, taken together, 47 out of the 79 hospitals are bothered by the noise of trucks.

Next to trucking came the noise made by children playing. This was listed as "vital" by 21 superintendents and as "significant" by 19. Fire apparatus, listed six times under "vital" and six times under "significant," was tied for third place with street cars whose noise was called "vital" seven times and "significant" four times. In all, 39 separate nuisances were listed.

The Sixteenth Annual Clinical Session of the American College of Physicians will be held in San Francisco, next April 4-8, according to a recent announcement by Dr. E. R. Loveland, executive secretary of the college. The Palace Hotel has been chosen as the headquarters hotel, where the general sessions, registration and exhibits will be held.

Public Health Problems Are Discussed in Interesting Program at Well-Attended Annual Conference of Ohio Health Commissioners

From the standpoint of attendance, interest, enthusiasm, and quality of program, the Twelfth Annual Conference of Ohio health commissioners with the State Department of Health, held November 18, 19 and 20, at the Deshler-Wallick Hotel, Columbus, was regarded by many as the most successful get-together of official public health workers ever held in Ohio.

The official registration for the three-days meeting included 83 county health commissioners, 23 of whom also were city health commissioners; 58 city health commissioners; 173 public health nurses, and 33 guests, a total registration of 347 which did not include members of the various divisions and bureaus of the State Department of Health.

Every session of the conference was well-attended and the varied and well-balanced program covered a wide range of important public health questions.

The first session was held Wednesday afternoon, November 18, with Dr. H. G. Southard, state director of health, presiding.

In behalf of Governor George White, who was unable to attend and address the gathering because of injuries received in a recent automobile accident, Dr. Southard conveyed the greetings of the Chief Executive to the health commissioners, nurses and guests, and quoted Governor White as pledging his fullest support and cooperation to the work of every official health department in the state.

Dr. Southard sounded the keynote of the conference in his annual address, a comprehensive, well-prepared and interesting review of the work of the State Department of Health during the past year and a summary of some of the important problems of the near future.

Reviewing the financial problems confronting the state department, Dr. Southard pointed out that although the budget of the department had been slashed in accordance with the economy move of the state government, resulting in the loss of 37 in personnel and the temporary elimination of two divisions, the state department is at the present time carrying on energetically and effectively every essential activity.

Outlining the department's policies with respect to clinics, demonstrations, immunization campaigns, and similar activities, Dr. Southard pointed out that the assistance of the state department would only be given upon the request of official local health departments after the project had been approved by the organized medical profession of the community. He emphasized especially the desirability and necessity for close cooperation between official health departments and the county medical societies, declaring that the state department would not approve of activities and projects that were objectionable to the organized medical profession of the various counties.

Dr. Southard said that the state department welcomed the support of non-official health agencies and declared that the department would do everything possible to co-ordinate all health activities in the state, whether official or non-official, along ethical medical lines for the betterment of public health in Ohio.

A composite picture of the extensive activities of the State Department of Health during the first 10 months of this year was drawn by Dr. Southard through brief reviews of the work of the various divisions and bureaus.

He pointed out that 2,599,520 pieces of printed matter had been handled by the bureau of publicity, including 221,791 pieces of departmental literature and 250,000 forms, report cards and kindred items. Dr. Southard also called attention to the increase in the circulation of the *Ohio Health News*, official semi-monthly publication of the department, which is now distributed in every state, every United States possession, and practically every civilized country in the world.

Relative to the work of the Division of Child Hygiene, Dr. Southard called attention to the fact that, of the 266 pre-school health conferences held in the state since January 1, 177 had been aided by examiners from the State Department of Health and the rest by departmental nurses or through information and literature supplied by the department. He said that 6,843 children had been examined at these preschool clinics with 25,880 defects reported. Dr. Southard reviewed the work of the department in health education, pointing out that one lecturer had been constantly occupied and others utilized as needed, in addition to the large amount of literature and articles distributed. During the 10-months period, 610 lectures were delivered to audiences aggregating 66,902 persons by departmental representatives, exclusive of county fairs.

The Bureau of Hospitals listed, checked and approved 342 hospitals of all types, including 196 maternity hospitals, since the first of the year, Dr. Southard said.

The work of the Division of Industrial Hygiene included among other things, he stated, the work of checking up on 1,112 reported cases of occupational disease; 98 cases of carbon monoxide poisoning, and research activities in the field of industrial health hazards.

Dr. Southard deplored the fact that, despite the efficacy of immunization against diphtheria, during the past year there were 40 general and 52 city health districts reporting less than 100 cases of immunization done. He pointed out that the Division of Communicable Diseases had assisted 13 city and 11 general health districts in Schick testing 28,696 children and in administering 49,423 immunizing doses, in addition to making special investigations of outbreaks of infectious diseases in five localities, including four state institutions, the most serious of which was the typhoid outbreak at the Cleveland State Hosiptal, and in classifying 100,715 communicable disease report cards from which regular reports for the benefit of the health commissioners were compiled. Dr. Southard said that with the exception of scarlet fever, all reportable diseases have shown decreases in number since the first of the year.

Tuberculosis shows an increase in the case rate, Dr. Southard revealed. He said he believed this was due to improvement in reporting and the fact that cases are being sought for and found in an early stage. At the same time, he pointed out, there has been a decrease in the death rate from tuberculosis, which he ascribed to public education, early diagnosis with better subsequent care and treatment, increased number and use of tuberculosis hospitals, and the increased utilization of fresh air and sunshine. During the past 10 months, nine diagnostic chest clinics were held in as many counties, with a total of 446 individuals examined, he reported.

Dr. Southard described at length the work of the department, especially the Division of Sanitary Engineering, in combatting public health menaces resulting from the drought and in providing water supplies for the 27 counties of southern and southeastern Ohio which suffered the most from the prolonged water famine. He also spoke of the cooperative program between the federal government and the State Department of Health now under way in these counties.

Work of the other divisions and bureaus of the department were similarly reviewed by the Director who also discussed the plan of the department to assist the State Department of Public Welfare in a campaign of immunization and vaccination among the wards of the various welfare institutions of the state to prevent, if possible, another epidemic similar to the typhoid outbreak at the Cleveland State Hospital.

In concluding his address, Dr. Southard made an emphatic plea for continued cooperation and activity among official public health workers and all others interested in public health questions, and suggested that the goal of health workers generally should be "fewer uplifting organizations, fewer departments, less duplication, fewer accidents and better health work". He also recommended that support be given to a suggestion for a post-graduate course in public health at Ohio State University, entrance being based on a degree in medicine or nursing.

DR. PLATTER DISCUSSES QUESTION OF MUTUAL IDEALS AND ETHICS

Two addresses of general interest, one by Dr. H. M. Platter, Columbus, president-elect of the Ohio State Medical Association, and the other by Dr. Charles A. Neal, state director of health in 1929-30, and since January 1, 1931, associate executive secretary of the Ohio Public Health Association, were delivered after Dr. Southard concluded his report.

Speaking on "Mutual Ideals of the Medical Profession in Official Public Health Work and Private Practice", Dr. Platter expressed the opinion that a better ideal for physicians, whether engaged in private practice or in official public health work, could not be found than that set forth in the code of medical ethics to which every physician subscribes upon entrance to his profession and which states that the prime object of the profession is "service to humanity".

"It was not the intention of legislation or the desire of the profession that a physician chosen for administrative health work should detach himself from his profession nor, in my opinion, is it desirable for him to believe that after his appointment he is not answerable to the same code of ethics", Dr. Platter declared.

"Many of the difficulties," he continued, "which have arisen from time to time have been occasioned by the fact that this point has been overlooked or ignored. A physician serving a health department will contribute a better service if he is closely identified with his county medical society and if his program is endorsed by that organization. On the other hand, every physician is obligated to do his part in public health education and to subscribe to and support health laws."

Dr. Platter pointed out that in the discharge of his duties to the patient, the physician is legally bound to use skill, care and diligence of the time and place, and that in the discharge of his duty to the public, the physician is morally and ethically bound to give full and complete cooperation to the administrative policy of his board of health when that policy meets with the approval of his county medical society. He stated that in his opinion there is a uniformity of procedure in Ohio generally, due to the fact that the roster of the Ohio State Medical Association usually shows the health commissioner to be an active member of his county medical society and, therefore, in accord with the policies of organized medicine in his county and in the state.

"Under such an arrangement harmony is promoted, cooperation is assured and the ideals of the profession are adhered to", Dr. Platter declared, adding that he considered the physician

who limits his practice to public health work to be as integral a part of the medical profession as any other practitioner who is restricting his practice to a particular field, and, therefore, answerable to the same code of ethics and the same ideals.

To emphasize what he termed a practical application of the mutual ideals of the physician in private practice and in public health administration and of the cooperative and harmonious spirit which should exist in sound public health work, Dr. Platter reviewed an article by Geib and Vaughn, published in the August 8, 1931, issue of *The Journal of the American Medical Association*, outlining the procedure and program of the Detroit Department of Health in making available to the people of Detroit, through the office of the family physician, the facilities now recognized as available in the modern health department. He pointed out that the article stated that 1100 Detroit physicians are actively engaged in the practice of *preventive* medicine; that the public has been prepared for the service which may be rendered by the physician and at the same time the physician has been prepared to give the type of service to which the public is entitled, every step in the program having been taken with the sympathetic support of the organized medical profession of Detroit.

"This plan closely adheres to the original intent of legislation creating health departments, follows the provisions laid down in our code of ethics, and avails itself of the service of each physician," Dr. Platter said.

In conclusion, Dr. Platter referred to the destructive criticism that has been hurled at the medical profession during the past few years and to the fallacious theories advocated by those who favor the complete socialization of medical practice.

"I know of no other profession which so constantly strives to improve itself," he said.

"The increase in requirements for entrance to the profession, the advances in treatment and in the field of public health, in the operating room and at the bedside abundantly bear witness to this fact. The result is a better quality of service—critics to the contrary, notwithstanding.* *

"We are abundantly able to solve our own problems. We need no guardian. There is a studied effort at the present time to socialize medical practice and substitute a practice by the state. To this course medical education and physicians generally are opposed, primarily because we believe the quality of medical service will suffer and that medical and surgical advances will be halted. These advocates need to be advised that retrenchment is imperative all along the line. We shall probably have less government instead of more government and probably shall witness more development of individual initiative. Is it too much to hope that we shall emerge from our present period of depression with a rehabilitation of the home and parental authority? Finally, shall our people not be brought to realize that they must depend upon themselves? This was the idea our forefathers had and embodied in the original constitution.

"Our ideals and our obligations are mutual. They call for undertsanding and cooperation in order to render the service without pauperizing the individual. When approached to join a new health movement, no matter how respectable it appears, we should satisfy ourselves that it has the endorsement of our county medical society and that it does not violate the policies of the state and national associations. Racketeering is possible under the magic name of 'health'."

CONTRIBUTIONS OF NON-OFFICIAL HEALTH GROUPS EVALUATED

Dr. Neal, discussing the subject, "Contribution of Non-Official Agencies to Public Health and Their Relationship to Official Service", opened his address by citing examples of the beneficial contributions of public health and public health work of various non-official health agencies and voluntary organizations interested in public health problems. He reviewed at some length the programs and projects that have received the support, financially and morally, of health groups composed for the most part of public-spirited laymen.

One of the chief problems in present-day public health administration, according to Dr. Neal, is how to adopt and to utilize properly the ideas and programs advanced and sponsored by lay or non-official agencies in official public health administration.

Dr. Neal declared that in his opinion successful public health administration and good public health work rests on a tripod made up of the medical profession, the official public health service and the non-official agencies, and that the support of each unit must be obtained to insure efficient public health work in every community.

Analyzing the work of each of these three groups, Dr. Neal said, in his opinion, the functions of the medical profesison in public health work should be curative and preventive, that of the official agencies, preventive and educational, and that of the non-official groups, educational and demonstrative. He declared that he believed in many communities these three groups are functioning as described and that successful public health work is being done.

Dr. Neal declared that in modern public health administration the administrator need not necessarily have an extensive knowledge of medicine or medical subjects since it is possible to employ physicians to handle matters requiring professional and scientific skill and knowledge. However, he asserted, the successful health administrator must have a thorough knowledge of public

health problems and technic, be a student of psychology, and have an intense interest in his work. Dr. Neal said that some persons interested in public health work are of the opinion that individuals in other professions besides the medical profession have just as good a claim on administrative duties in public health work as physicians and that some outside of the medical profession have proved themselves successful public health administrators. He added, however, that he felt the physician, providing he had the qualifications enumerated, in addition to his knowledge of medicine and medical subjects, would be the most desirable person as a leader in public health work.

In recent years, non-official agencies have been able to accomplish good results in some lines of public health work, because of the large funds at their disposal, and because they were not restricted by political obstacles or by problems involving professional ethics, Dr. Neal declared.

However, he added, non-official groups have made mistakes because of over-enthusiasm and because they have rushed headlong into unsound and fallacious programs without the cooperation and guidance of the medical profession and official public health units. Dr. Neal also pointed out that trespassing and needless duplication had likewise resulted from this failure to coordinate the resources of the three units on which public health work is based. He said that he believed the lay or non-official health agency had a definite place in public health work, and that it could be of distinct value by aiding the official agency in public education and by staging demonstrations, clinics, etc. Dr. Neal said that he felt the non-official agencies have developed many ideas and projects that are of value in the modern public health program, and that those of proved value should be absorbed by the official units and supported by public funds. He said there is a great need for making non-official agencies an integral part of public health work, and that every health administrator should endeavor to obtain the support and cooperation of the lay groups in his district, and should in turn utilize their ideas and programs in official public health service, so far as possible.

In conclusion, Dr. Neal referred again to the tripod upon which he believes modern public health work rests and emphasized the importance of developing each unit to the fullest extent, and then coordinating the activities of all three.

Dr. Neal cited examples of how this coordination had been accomplished with considerable success through a central council or federation composed of representatives of various professional, official and non-official groups interested in medical and health questions, mentioning particularly such organizations now functioning in Cincinnati and Cleveland. He suggested that health workers in every community consider the possibilities of such a centralized coordinating unit, expressing the opinion that it would help to eliminate duplication of time and effort, produce efficiency in public health service, and tend to bring about cooperation and mutual understanding between all groups engaged in public health projects.

The Wednesday session was concluded by a talk on "How to Utilize Health Department Literature and Supplies", by Paul Mason, chief of the Bureau of Publicity, State Department of Health.

CHANGE IN SOCIETY'S NAME FAVORED BY COMMISSIONERS

One session of the conference—that on Thursday morning—was devoted to the annual meeting of the Ohio Society of Sanitarians, the membership of which is composed of health commissioners, public health nurses and other health department employes.

Dr. Frederick M. Houghtaling, health commissioner of the city of Sandusky and Erie County, was elected president for the coming year, succeeding Dr. J. J. Sutter, Lima. Dr. E. R. Shaffer, chief of the Bureau of Local Health Organization, State Department of Health, was re-elected secretary-treasurer.

Among the chief business matters taken up at the session was the question relative to the continuance of the society and, if so, the question of changing the name of the organization.

A number of health commissioners, including Dr. Sutter, retiring president and presiding officer, expressed the opinion that the society should be continued, their opinions meeting with the unanimous approval of those in attendance.

Dr. Sutter suggested that the organization broaden and extend its program, and take a more active part in legislative matters affecting public health. He expressed the opinion that the society should consider the possibility of establishing a central office, with permanent headquarters and a paid executive secretary.

The question of changing the name of the society was brought before the membership through a report of a special committee on change of name, headed by Dr. M. D. Ailes, Akron.

Dr. Ailes, in reporting for his committee, stated that a canvass had been taken among many health commissioners throughout the state relative to changing the name of the society and that numerous suggestions had been made. He said some of the names suggested were: Ohio Society of Public Health Workers, Ohio Society of Public Health Officials, The Ohio Public Health Workers Association, The Ohio Society of Health Commissioners and Public Health Workers, and The Ohio Public Health Society.

Dr. Ailes said that his committee recommended that the name of the society be changed but sug-

gested that the matter of selecting a new name be left to the executive committee, with power to act.

During a discussion of the question, many expressed the opinion that the name of the society should be changed to the Ohio Public Health Association, but it was pointed out that this was the title of an existing lay unofficial organization and that it would be impossible to obtain the use of it unless the other organization would be willing to change its name. Some of those who discussed the question expressed the belief that the name "Ohio Public Health Association" is a misnomer for any organization other than one composed of official public health workers, or for any organization with a limited or specialized field of activity.

Through the adoption of a resolution, the society went officially on record as favoring a change in the name of the society; left the question in the hands of the executive committee, and suggested that a poll of the membership be taken by the executive committee to obtain opinions from the members as to which of the names suggested by the special committee would be most desirable.

Dr. Shaffer, in reviewing the activities of the society during the past year, stated that it was the belief of the executive committee that the society should sponsor and finance an official bulletin to be issued at least quarterly, and more often if practical. Dr. Shaffer said that the Ohio State Medical Association in its official *Journal* and the *Ohio Health News*, official publication of the State Department of Health, had always been most cooperative in publishing the happenings and news of the annual conference and in publishing from time to time some of the papers presented at the annual meeting of the society, which cooperation was greatly appreciated by the executive committee. However, he pointed out, these two publications are unable to publish all the essays and discussions delivered at the annual conference or to publish special literature which the society might wish to issue to its members from time to time. Dr. Shaffer said that the executive committee had held several conferences with one publisher relative to the matter of issuing a periodical for the society and that at the present time negotiations were still under way.

At the conclusion of his report, the society expressed itself in favor of a publication and delegated to the executive committee the responsibility of making the necessary arrangements after further conferences and negotiations.

Resolutions prepared by a committee consisting of Dr. E. R. Hiatt, Troy, Dr. N. Sifritt, Marion, and Dr. R. W. DeCrow, Portsmouth, included:

A recommendation that official public health workers of Ohio continue the mutual cordial relations between all volunteer organizations interested in public health problems and with the organized medical profession.

A recommendation that the Ohio Society of Sanitarians cooperate with the advisory committee of the College of Medicine, Ohio State University, in charge of the collection and distribution of convalescent serum for the treatment of infantile paralysis and assist in every way possible in the collection and maintenance of such records as are necessary incident to the project.

Reiteration of the policy of the society favoring a change in the method of appointment of the State Director of Health, i.e., that such appointment should be made by the Ohio Public Health Council for a term of at least six years instead of by the Governor for a term of two years.

Expression of sorrow and regret concerning the deaths of Dr. H. H. Snively, Columbus, former state director of health; Dr. L. G. Bean, chief of the Bureau of Dental Hygiene, State Department of Health; Dr. Herman O. Hodson, health commissioner of Highland County, and Dr. Morton W. Bland, health commissioner of Hocking County and Logan.

Previous to adjournment of the business session, Dr. Robert Lockhart, health commissioner of Cuyahoga County, and chairman of a special committee of the Northeastern District of the Ohio Society of Sanitarians, submitted a report advocating numerous changes in the annual report form which all health commissioners are required to file with the State Department of Health. The revisions suggested by the committee were approved by the society and it was recommended that the state department give the suggestions careful consideration in making up forms for the ensuing year.

NURSING PROBLEMS DISCUSSED AT WELL ATTENDED SESSION

A record-breaking attendance of public health nurses was one of the features of the conference —there being 173 registered for the meeting.

A special session for nurses was held Thursday morning with Mrs. Clara Coburn, R.N., chairman of the hostess committee presiding. Other members of the committee which arranged the program for the session were: Miss Helen Felkner, R.N., Miss Inez Gilliland, R.N., Miss Harriet Luce, R.N., and Miss M. Florence Tallman, R.N.

A timely discussion relative to the work of the Ohio State Nurses' Association in an effort to relieve unemployment among registered nurses in Ohio and aid them during the current economic depression was given by Mrs. Elizabeth P. August, R.N., Columbus, general secretary of the Ohio State Nurses' Asociation.

Speaking on the subject, "The Service Division of the Ohio State Nurses' Association and Its Value to Public Health Nurses", Mrs. August reviewed the activities of that division from the time of its organization in 1927 for the two-fold purpose—to further the efficient care of the sick and assist well qualified nurses in obtaining employment.

The Service Division, Mrs. August explained, does not attempt to find special duty nursing

positions for applicants for jobs, leaving that up to the nine Official Registries for Nurses located in as many cities throughout the state, but offers information and guidance in placing nurses in all other fields of nursing such as hospital positions, industrial and office nursing, public health nursing, etc.

Mrs. August pointed out that the service has been extremely popular with nurses desiring positions other than private duty nursing, as well as with hospitals, health departments, factories, and insurance companies seeking competent and qualified nurses. She said that, during the period July, 1927, to November 1, 1931, a total of 136 nurses had been placed with hospitals, health departments and other organizations, and that 40 hospitals maintaining accredited schools of nursing and 18 not maintaining nursing schools are using the service offered by the division when needing nurses.

Mrs. August said that the Service Division is endeavoring to interest more hospitals without nursing schools to employ graduated registered nurses instead of "attendants" who are receiving a salary equal to that of the graduate registered nurse.

Mrs. August pointed out that the Service Division is an organization not for profit and that the amount of service rendered the nurse seeking employment far exceeds the small fee charged.

"Administration of Public Health Nursing Service in Ohio" was the subject presented by Dr. E. R. Shaffer, chief of the Bureau of Local Heatlh Organization of the State Department of Health.

Dr. Shaffer expressed the opinion that a public health nursing program, carried on by tactful, diplomatic and experienced nurses, constitutes one of the most important activities of state and local public health administration, and that Ohio's public health nursing service generally is outstanding compared with similar programs in other states.

Dr. Shaffer said that he believed a nurse should have special qualifications for this particular type of service, these qualifications to include graduation from an accredited school of nursing, registration in Ohio by virtue of examination or reciprocity, and completion of a course in public health nursing or practical experience in this work under adequate supervision.

The public health nurse, if she hopes to be instrumental in providing a successful and effective program as a part of practical and efficient public health administration, according to Dr. Shaffer, should carry out the principles and ethics taught while pursuing her training; practice these principles at all times in her dealings with the medical profession and the health officials of her district; cooperate in every way possible, and be tactful in her contacts with physicians, health officials and the public.

Relative to the relationship which should exist between the public health nurse and the health commissioner of her district, Dr. Shaffer said that, in brief, it should be the same as that which should exist between the practicing physician and the registered nurse on a private case.

"What does the health commissioner expect of the public health nurse?" Dr. Shaffer asked.

Answering this question, Dr. Shaffer said that, first, the health commissioner expects the nurse to execute the job efficiently, without duplication of effort, and in a balanced manner; second, that the nurse keep him informed of her work through complete and accurate monthly reports; and, third, that she form a tactful and important contact between the health commissioner's office and the public and the medical profession.

The public health nurse has a splendid opportunity to know the public's mind and to know and work with the medical profession, Dr. Shaffer observed, adding that in some instances physicians are critical of the public health nursing service of their community, primarily, because the nurse has not taken the trouble to familiarize them with her work and what she is trying to accomplish.

In a description of the evolution of official public health administration, Dr. Shaffer outlined briefly the chief phases of Ohio's public health nursing program, as follows:

Maternity and infancy work, with emphasis on individual case work; preschool conferences in cooperation with local agencies; assisting school physicians in the supervision of the health of school children; assisting, but not performing the duties of the sanitary officer or diagnostician, in communicable disease control; active work in tuberculosis control and in organizing chest clinics in cooperation with the local medical profession; work among crippled children.

Two other papers were read at the Thursday morning session of the public health nurses' section. One, "Reports and Records of Public Health Nurses; Uniformity, Value and Purposes Served," was presented by Miss Helen Felkner, R.N., field representative, State Department of Health. The other, "Public Health Nursing Program in the Drought Area", was read by Miss Harriet Luce, R.N., field representative, State Department of Health.

At noon, Thursday, several hundred nurses and guests attended a luncheon presided over by Miss Augusta Condit, chief of the Division of Nursing, Columbus Department of Health.

The principal speaker at the luncheon was Miss Marian G. Howell, R.N., director of the School of Public Health Nursing, Western Reserve University. Miss Howell spoke on, "Benefits to be Derived from a Generalized Public Health Nursing Program". Miss Loneta M. Campbell, R.N., advisory public health nurse, Wauseon, led the discussion which followed Miss Howell's talk.

DR. SNIVELY EULOGIZED AT LUNCHEON HONORING DR. FREEMAN

The honored guests on Friday, the closing day of the conference, were Dr. Allen W. Freeman, professor of public health administration, Johns Hopkins University, Baltimore, and former state health commissioner of Ohio, and Dr. Kendall Emerson, New York City, managing director of the National Tuberculosis Association and acting executive secretary of the American Public Health Association.

A largely attended luncheon, Friday noon, was given in honor of Dr. Freeman, with Dr. C. O. Probst, Columbus, member of the Ohio Public Health Council, a pioneer in public health work in Ohio, and for many years secretary and administrative director of the old State Board of Health, presiding as toastmaster.

Seated at the speakers' table with Dr. Probst were: Dr. Freeman, Dr. Emerson, Dr. E. F. McCampbell, former secretary of the old State Board of Health, Dr. H. G. Southard, present state director of health; Dr. Charles A. Neal, predecessor to Dr. Southard; James E. Bauman, assistant state director of health, who has been connected with official public health work in Ohio for more than a quarter of a century; Paul Mason, chief of the Bureau of Publicity, State Department of Health, an intimate personal friend and associate of the late Dr. H. H. Snively, Ohio's first director of health; Dr. W. I. Jones, D.D.S., Columbus, and Dr. George D. Lummis, Middletown, member of the Ohio Public Health Council.

Following the luncheon, Dr. Freeman was toasted by those present and he responded with a brief review of some of the problems which he confronted during his tenure of office as health commissioner of Ohio.

Dr. Emerson, following an introduction by Dr. Probst, conveyed to the conference the greetings of the American Public Health Association and pledged the cooperation and support of his association to official public health work in Ohio.

All at the speakers' table were presented by Dr. Probst and responded with brief talks, Mr. Mason's being in the form of a eulogy to the late Dr. Snively, described by the speaker as "a good soldier, a gallant gentleman, a loyal friend, and a true minister of healing to the sick of body, and mind, and soul". Following Mr. Mason's touching expression of appreciation of Dr. Snively, those attending the luncheon arose and drank a silent toast to the memory of the first of Ohio's state directors of health to pass on.

NEW TECHNIC IN RURAL HEALTH WORK NEEDED, SAYS DR. FREEMAN

High spot of the concluding session of the conference was an address by Dr. Freeman in which he traced the development of rural public health administration and analyzed some of the important problems and questions confronting official public health workers in rural sections at the present time.

While rural public health administration is not a new idea, Dr. Freeman pointed out, its greatest advance has been recorded during the past 20 years. Previous to about 1910, he said, rural public health work was a haphazard affair, carried on by a multitude of small, disjointed and disconnected units, headed for the most part by poorly qualified individuals, usually laymen, and seldom on a full-time basis. Since the rural home in the old days was somewhat similiar to an absolute monarchy and community enterprise was still in its infancy, the old public health programs dealt mostly with communicable diseases and were used mostly as an emergency service, Dr. Freeman pointed out. When an epidemic broke out, the health board of the district would organize, pick a health officer, and proceed to combat the prevalent disease, he said, disbanding, usually, after the outbreak had been placed under control. Dr. Freeman observed that it was not believed in those days that the health officer should be a physician and that as a general rule the person selected for the job was someone who, it was felt, would be as inactive and inconspicuous as possible.

About 1910, Dr. Freeman said, a change took place in the conception of what a public health officer and public health department should do, and in the East, the idea developed that the work could be improved and made more efficient through the organization of a state department, employing deputies, to coordinate the services of the numerous local units. Shortly thereafter, Dr. Freeman said, John D. Rockefeller gave $1,000,000 for research in hookworm in the southern states from which developed the idea of full-time county health officers and departments, since it was learned from the hookworm program that little of permanent value could be accomplished through spasmodic campaigns or periodical demonstrations. Dr. Freeman referred to the fact that Ohio was the first northern state to organize its health service on a full-time county basis and that it has continued to lead the nation in many phases of official public health work.

Analyzing in general the present-day rural health programs, Dr. Freeman declared there are numerous lessons to be learned from the work and some very important questions which should be seriously considered in the administration of public health service in rural areas.

In the first place, Dr. Freeman asseverated, it should be understood that rural public health administration is a difficult business and in most instances complicated by the personal factor which does not bob up so frequently in public health work in cities and urban communities. The rural health officer must be tactful and diplomatic, he said, since practically everyone with

whom he comes into contact is a friend or an acquaintance, and because of the many complicated questions which arise in a small, neighborly community that are unknown in the congested urban centers.

Secondly, Dr. Freeman emphasized, in too many instances the county health department is urged and expected to undertake programs which are not only too complicated but entirely unsuited for the particular district. He pointed out that the average county health department has insufficient personnel, inadequate finances, and is confronted with too many peculiar local problems to be expected to carry on specialized programs and campaigns in the fields of tuberculosis, heart disease, cancer, child hygiene, etc.

Dr. Freeman observed that he believed most county health officers were attempting to shoulder all the responsibilities placed upon them, including many specialized programs, and were trying hard to succeed, but that in most cases they "just can't swallow it".

In this connection, Dr. Freeman emphatically declared that he believed there is a great need for a new technic in rural public health work, basing his observations on reports from some of the extensive demonstrations which have been financed by large foundations. To illustrate his point, Dr. Freeman discussed the present-day programs in child hygiene.

Child hygiene work in the city is comparatively easy and is meeting with marked success in many places, he said, because the personal factor is at a minimum in the urban area, because many sections of any large city do not have neighborhood physicians, and because such work, if properly supervised and directed, can be carried on successfully without criticism from the medical profession since the great majority of city physicians are either too busy with private practice to give it any thought or are anxious to take part in the work to gain the experience which the work affords.

In rural areas, the picture is quite different, Dr. Freeman stated. In the first place, he pointed out, few rural communities have a sufficient number of trained specialists necessary for efficient operation of a child hygiene clinic. In the second place, Dr. Freeman observed, the problem of transportation and distance is encountered, curtailing attendance at the clinic, and obstructing county-wide enthusiasm in and for the project. Finally, Dr. Freeman said, specialized projects of this nature are almost certain to meet with the disapproval of the organized medical profession of the rural community, and, as he pointed out, with justifiable reasons. The family physician is still a vital influence in practically every rural area, he said, and almost every rural family has its own doctor to whom it looks for guidance in all health and medical matters, which means that the country doctor is quite unlikely to favor any program which might disrupt the close personal relationship existing between him and his patients. Another factor, Dr. Freeman pointed out, that must be considered in this instance is the matter of income. He declared that many rural physicians now are hard pressed to make enough to provide them with a comfortable living and meet their overhead, so that they would assuredly be justified in opposing any project which might have a diminishing effect on their already meager income.

Passing on to additional lessons being learned in rural public health administration, Dr. Freeman said that he believed many county health commissioners are neglecting the personal contact phase of public health education and depending too much, if not entirely, on newspaper articles and official bulletins to get their messages across to the public.

Dr. Freeman also expressed the opinion that too often the very fundamentals of public health work—communicable disease control and simple, elementary sanitation—are neglected.

He emphasized the fact that it is highly impractical and poor management for the health department to engage in any of the many and varied specialized health programs until it has met its responsibilities with regard to control of communicable diseases and sanitation.

There is no use to teach the young mother how to feed her baby if insanitary conditions exist in the community or communicable diseases are widespread, causing conditions that are liable to take the life of the most efficiently fed infant, Dr. Freeman declared, adding that real progress in public health work is being accomplished in those areas where sanitation and communicable disease control are placed ahead of all special programs.

In conclusion, Dr. Freeman stressed the necessity and desirability of local initiative and local activity in public health administration. The successful health commissioner, he said, is the one who is not afraid to try things; wins the cooperation of his local medical society, and uses his effort and ability in endeavoring to work out his own local problems. The health officer, especially in the rural community, cannot expect to be handed a ready-made program that will be applicable in every particular to local conditions—it is his business and his responsibility to formulate an elastic program capable of meeting questions and problems unique in his own locality and not depend wholly on standardized programs and centralized personnel to provide the necessary service, Dr. Freeman concluded.

The final session of the meeting was concluded with an address on "Registration of Births and Compilation of Deaths" by I. C. Plummer, chief of the Division of Vital Statistics, State Department of Health; a review by Dr. W. I. Jones, D.D.S., of a paper prepared by the late Dr. L.

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G. Bean, chief of the Bureau of Dental Hygiene, State Department of Health, on the dental hygiene program of the state department, and a brief discussion relative to cooperation and coordination between health departments of neighboring and adjacent counties by Dr. J. D. Boylan, Milford Center, health commissioner of Union County.

CAMPAIGNS AGAINST DIPHTHERIA AND POLIOMYELITIS REVIEWED

An interesting and educational symposium on procedure in immunization against diphtheria, selection and dosage of various kinds of immunizing agents, and the use of human convalescent serum in the treatment of poliomyelitis featured the Thursday afternoon session of the gathering which was presided over by Dr. G. T. Wasson, health commissioner of Crawford County.

Essentials in a program of procedure leading up to and effecting a successful program of immunization against diphtheria were outlined in a paper presented by Dr. H. H. Pansing, health commissioner of Montgomery County.

Dr. Pansing opened his remarks with the observation that in his opinion immunization work rightfully belongs to the family physician, should be carried out by him, and should be encouraged by him in his contact with his patients. He said that every county medical society should be requested to conduct an immunization program at stated intervals, with the assistance of the local health department, and that the health department should not assume the entire responsibility for the work unless it is the desire of the medical profession that it do so, or the medical society fails to carry on a successful campaign of immunization.

Before an immunization program is attempted by the local health department, the following essential factors must be present, Dr. Pansing declared:

(1). The health commissioner must be sold on the idea of immunization and must be willing to enter the campaign with enthusiasm and energy.

(2). A well-balanced, conservative and concerted educational campaign must have been completed; sensational and spasmodic campaigns of education are undesirable.

(3). Before the immunization is started, there must be assurance that those doing the work have a thorough scientific knowledge of the technic involved and the public should be informed regarding some of the important features of the work.

After a campaign has been decided upon, Dr. Pansing suggested that the following steps should be taken:

(1). Local records and statistics should be carefully studied and analyzed.

(2). The plans should be sold to the local board of health in order to obtain its wholehearted support and cooperation.

(3). Conferences should be held with the local organized medical profession; procedure should be discussed with the society, and the campaign mapped out so as to win the aid and cooperation of local physicians.

(4). Personnel of the health department should be well-organized and qualified to carry on the work required of it; the office routine should be systematized, and an efficient system for compiling and filing records should be established.

(5). Educational data, information and literature should be distributed through the press and otherwise to arouse favorable public sentiment and to instruct the public concerning the immunization procedure and value of the work.

(3). Cooperation of school officials, school teachers and all groups and agencies interested in medical, health and social questions should be secured.

(7). Special educational efforts should be directed to parents with children of susceptible age.

(8). A strenuous effort should be made to win the confidence and cooperation of the children themselves in the program.

(9). During and after the immunization work, accurate and complete records should be kept as reference for future campaigns.

Dr. Pansing described fully the work accomplished in Montgomery County where a large percentage of the children of school age have been successfully immunized through procedure comparable to that which he had outlined. He said, in closing, that the work of the health department in diphtheria immunization should be for the most part educational once the medical profession has taken an active interest in the work and been sold on the idea that the private physician should and can take the leading part in the campaign.

A description of immunization procedure in Cincinnati, which has a record in the battle against diphtheria second to no other city in the country, was given by Dr. W. H. Peters, health commissioner of the Queen City. Dr. Peters said that Cincinnati is concentrating at present on pre-school immunization since a large percentage of the children of school age have already been immunized. He also commended the organized medical profession of that city for the splendid cooperation it had given and pointed out that between 60 and 75 per cent of all cases immunized are now being handled by physicians engaged in private practice.

Some of the obstacles and hardships encountered by the health commissioner in a rural community in immunization work were enumerated and discussed by Dr. F. R. Dew, health commissioner of Belmont County. Dr. Dew said that in some localities, such as mining districts and sparsely populated hill regions, it is practically impossible for the health department to accomplish much, due to the illiteracy of the people and their inability to understand the value of preventive medicine.

Dr. John E. Monger, Columbus, former state

director of health, reviewed the discussions which took place at the recent annual meeting of the American Public Health Association at Montreal concerning the relative merits of various kinds of immunizing agents and the importance of taking into consideration the age of the patient in selecting the serum to be injected. He also presented some interesting data relative to the number of injections for each kind of serum, the length of the interval between doses and the importance of proper refrigeration facilities for the storing of serum.

The progress which has been made throughout the country in combatting infantile paralysis through the use of human convalescent serum was discussed by Dr. E. G. Horton, professor of pediatrics, College of Medicine, Ohio State University.

Dr. Horton explained in detail the aims and activities of an advisory committee representing the College of Medicine in the collection and distribution of the poliomyelitis serum. He described the work which had already been done in Columbus in cooperation with the Columbus Academy of Medicine in the collection of blood from infantile paralysis victims and the accumulation to date of a limited supply of serum. Dr. Horton told of the desire of the committee to make the work a state-wide project and asked the assistance of all health commisisoners in the collection of records and pertinent statistics for use of the committee, and their cooperation in getting paralysis victims to contribute blood for making of the serum. He said that the committee hoped eventually to establish distribution stations throughout the state but that at the present time the work would have to be centralized in Columbus.

Dr. Horton made a scientific analysis of the use and value of the convalescent serum, emphasizing the fact that it is in no sense of the word an immunizing agency but is effective only in the *treatment* of paralysis cases. He said that experience has shown that the serum is as a general rule most effective when used in early stages of the disease and before the paralysis has set in, and that when used in the later stages, it is of only nominal benefit. Dr. Horton warned against placing too much reliance on the efficacy of the serum, stating that it was not infallible but that it has proved the most effective agency so far discovered for treating paralysis sufferers.

Dr. Horton stated that at present one of the most difficult problems faced by the committee in charge of distribution is that relative to determining if the case for which serum is requested is actually a case of infantile paralysis; whether the case, if a paralysis case, is in the early or advanced stage, and whether the serum would be of material assistance if used. He said the committee would be compelled to exert extreme care in the distribution of the serum, because of the limited supply, and would endeavor to emphasize to the medical profession the necessity for establishing an accurate and prompt diagnosis before making a request for serum.

"Public Health Problems of the State Department of Public Welfare", was the subject of an address delivered by State Welfare Director John McSweeney.

Mr. McSweeney said that because of the crowded and congested conditions in many of the state welfare and penal institutions, and inadequate facilities in practically all of them, health hazards were great, creating a problem which needed prompt solution. He urged the continued support of the state department of health and the health officials in the districts where the state institutions are located in attempting to meet the health questions arising at these institutions.

Mr. McSweeney praised the work of the state department of health and the health officials in Cuyahoga County and the City of Cleveland in the recent typhoid fever epidemic at the Cleveland State Hospital and expressed appreciation for the cooperation and aid of the state department of health in the present program to vaccinate and immunize the inmates of all state institutions against communicable diseases.

Speaking of the mental hygiene question generally, Mr. McSweeney said that the medical profession and public health officials must continue with their study of the causes of mental illness; that they must assist in the rehabilitation of these unfortunates; that they must endeavor to give the inmates of the state institutions strong bodies so that they can wage a more determined fight against their mental illness; that they must cooperate in aiding the state ward upon his return home, watching over his health and keeping him physically fit to become a producer and to overcome, if possible, a reoccurrence of the mental affliction.

SANITATION BACKBONE OF PUBLIC HEALTH WORK, MILLER DECLARES

Sanitary engineering problems and sanitation generally were discussed at considerable length at Friday morning's general session, presided over by F. H. Waring, chief of the Division of Sanitary Engineering, State Department of Health.

The principal address was delivered by H. E. Miller, a member of the sanitary engineering staff of the United States Public Health Service, who has been engaged in public health work for the past few years in a number of southern states.

Discussing the subject, "Rural Sanitation Problems", Mr. Miller defined sanitation "as the common sense application of the rules of cleanliness" and declared that, despite opinions to the contrary, Ohio still has a rural sanitation problem. He

cited the high mortality and morbidity rates from typhoid, enteritis and other water-borne diseases in the rural counties of the state to emphasize the present need for better sanitation in some sections of Ohio.

Sanitation is the foundation of public health and public health work, Mr. Miller declared, asserting that in his opinion public health work has lost momentum during the past few years because too much emphasis has been placed on individual health problems and not enough on community health questions, the biggest one of the latter class being sanitation.

Reviewing briefly the history of public health work, Mr. Miller said that he believed at the present time public health work is slightly out of balance, with too much time and effort being wasted on paternalistic projects for the benefit of a few individuals and not enough being placed on enterprises that would be beneficial to the entire community.

Mr. Miller pointed out that the question of friction between public health departments and the practicing medical profession is raised in some localities. He said that this was an unnecessary as well as undesirable thing, declaring that public health workers to succeed must have the cooperation and support of the medical profession and that these may be obtained in any community if the right policies are formulated and the right tactics pursued. He cautioned public health officials to "stay in their own backyard", adding that he felt no one, including the medical profession, would in any way interfere with their activities but would give them valuable support, if they stuck to the fundamentals of public health work and did not get into paternalistic fields where infringement on private medical practice was a possibility.

An interesting and informative paper on "A Successful Milk Control Program" was read by Dr. J. M. Higgins, health commissioner of Athens County, which outlined the essential points in the program he has in operation in his county, making it a leader in milk sanitation in Ohio. Additional data on the Athens County work were given by Richard L. Marlow, food and sanitary inspector for the Athens County Health Department.

Problems of school building sanitation, school water supplies and school sewage disposal facilities were discussed by F. D. Stewart, assistant engineer, State Department of Health.

Leo F. Ey, chief of the Division of Laboratories, State Department of Health, reviewed the significance attached to biological water analysis, proper collection of water samples and the interpretation of laboratory results.

Ohio's "Seal of Safety" campaign, especially in the drought area, was outlined by C. S. Slade, assistant engineer, State Department of Health.

COMMISSIONERS, NURSES AND GUESTS REGISTERED AT MEETING

Following is a list of those who registered at the conference, exclusive of employes of the various divisions and bureaus of the State Department of Health:

Health Commissioners—Dr. S. J. Ellison, Adams County; Dr. J. J. Sutter, Allen County; Dr. G. B. Fuller, Ashland County; Dr. W. S. Weiss, Ashtabula County; Dr. J. M. Higgins, Athens County and the City of Athens; Dr. Roy C. Hunter, Auglaize County; Dr. F. R. Dew, Belmont County; Dr. W. L. Faul, Brown County; Dr. C. J. Baldridge, Butler County and City of Hamilton; Dr. J. H. Murray, Carroll County; Dr. L. A. Woodburn, Champaign County; Dr. R. R. Richison, Clark County; Dr. C. R. Colburn, Clermont County; Dr. W. K. Ruble, Clinton County and the City of Wilmington; Dr. T. T. Church, Columbiana County and the City of Salem; Dr. D. M. Criswell, Coshocton County and the City of Coshocton; Dr. G. T. Wasson, Crawford County; Dr. Robert Lockhart, Cuyahoga County, and the Cities of Cleveland Heights, Bedford, Berea, Euclid, Garfield Heights, Maple Heights, Parma, Rocky River and Shaker Heights.

Dr. W. D. Bishop, Darke County and the City of Greenville; Dr. B. B. Barber, Delaware County; Dr. F. M. Houghtaling, Erie County and the City of Sandusky; Dr. O. M. Kramer, Fairfield County; Dr. James F. Wilson, Fayette County and the City of Washington C. H.; Dr. H. L. Mitchell, Franklin County; Dr. W. E. Howell, Gallia County; Dr. Walter Corey, Geauga County; Dr. R. H. Grube, Greene County; Dr. D. L. Cowden, Guernsey County.

Dr. E. H. Schoenling, Hamilton County, and the City of Cheviot; Dr. S. F. Whisler, Hancock County; Dr. J. H. Holcomb, Hardin County; Dr. J. M. Scott, Harrison County; Dr. J. R. Bolles, Henry County; Dr. J. L. Walker, Highland County; Dr. W. B. Lacock, Hocking County and the City of Logan;

Dr. J. C. Elder, Holmes County; Dr. B. C. Pilkey, Huron County; Dr. J. W. Clark, Jackson County; Dr. J. P. Young, Jefferson County; Dr. C. B. Elliott, Lake County; Dr. F. R. Stewart, Lawrence County; Dr. Edward M. Cass, Licking County; Dr. W. H. Carey, Logan County; Dr. Henry R. O'Brien, Lorain County; Dr. F. F. Devore, Lucas County; Dr. Robert Trimble, Madison County; Dr. G. Y. Davis, Mahoning County; Dr. N. Sifritt, Marion County and the City of Marion; Dr. R. L. Mansell, Medina County and the City of Wadsworth; Dr. W. S. Ellis, Meigs County; Dr. F. E. Ayers, Mercer County; Dr. E. R. Hiatt, Miami County and the City of Troy; Dr. J. W. Weber, Monroe County; Dr. H. H. Pansing, Montgomery County and the City of Miamisburg; Dr. James B. Naylor, Morgan County;

Dr. R. L. Pierce, Morrow County; Dr. Beatrice Hagen, Muskingum County; Dr. G. M. Mason, Noble County; Dr. C. B. Finefrock, Ottawa County; Dr. C. E. Huston, Paulding County; Dr. F. J. Crosbie, Perry County; Dr. C. C. Beale, Pickaway County; Dr. O. R. Eylar, Pike County; Dr. Rollin D. Worden, Portage County; Dr. J. I. Nisbet, Preble County; Dr. Frank Light, Putnam County; Dr. Millard C. Hanson, Richland County and the City of Mansfield; Dr. R. E. Bower, Ross County and the City of Chillicothe; Dr. O. H. Thomas, Sandusky County; Dr. R. W. DeCrow, Scioto County and the City of New Boston; Dr. J. J. Heaton, Seneca County; Dr. B. S. Stephenson, Shelby County and the City of Sidney; Dr. Floyd Stamp, Stark County; Dr. R. H. Markwith, Summit County and the City of Cuyahoga Falls; Dr. L. A. Connell, Trumbull County; Dr. J. Blickensderfer, Tuscarawas County and the City of New Philadelphia; Dr. J. Dean Boylan, Union County; Dr. Charles Keyser, Van Wert County; Dr. Ed Blair, Warren County; Dr. Alfred G. Sturgiss, Washington County; Dr. W. G. Rhoten, Wayne County and the City of Wooster; Dr. H. J. Powell, Wood County and the City of Bowling Green; Dr. L. W. Naus, Wyandot County;

Dr. M. D. Ailes, City of Akron; Dr. C. B. Meuser, City of Ashland; Dr. H. A. Finefrock, City of Barberton; Dr. William E. Shepard, City of Bellaire; Dr. A. J. McCracken, City of Bellefontaine; Dr. W. G. Carlisle, City of Bucyrus; Dr. Hugh C. Thompson, City of Bexley; Dr. Clyde L. Vorhies, City of Cambridge; Dr. J. S. Mariner, City of Campbell; Dr. F. M. Sayre, City of Canton; Dr. W. H. Peters, City of Cincinnati; Lewis E. Miller, City of Circleville; Dr. Harold J. Knapp, City of Cleveland; Dr. N. C. Dysart, City of Columbus; Dr. Inez Hyatt, City of Conneaut; Dr. A. O. Peters, City of Dayton; G. O. Higley, City of Delaware; Dr. C. F. Savage, City of Delphos; Dr. G. W. Stober, City of East Cleveland; Dr. Ed Miskall, City of East Liverpool; Arthur S. Johnson, City of East Palestine; Dr. George F. French, City of Elyria; K. B. Clark, City of Findlay; L. W. Gibson, City of Fostoria Dr. F. L. Vermilya, City of Fremont; Dr. J. G. Mannhardt, City of Galion; Dr. D. R. Williams, City of Girard; C. R. Cornell, City of Grandview; Ruth Lunney, City of Kenton; Dr. Wallace J. Benner, City of Lakewood; Dr. C. B. Snider, City of Lancaster; Dr. J.

B. Poling, City of Lima; Dr. Valloyd Adair, City of Lorain; Dr. J. B. McClure, City of Marietta; John Donavan, City of Martins Ferry; John F. Williams, City of Massillon; Dr. George D. Lummis, City of Middletown; Dr. Julius Shamansky, City of Mt. Vernon;

Dr. Hubert Hyde, City of Nelsonville; Dr. W. H. Knauss, City of Newark; Dr. C. L. Bell, City of Norwalk; Dr. L. O. Saur, City of Norwood; Dr. H. W. Leutenschlager, City of Oakwood; Clara C. Wilder, City of Painesville; L. G. Whitney, City of Piqua; Dr. O. D. Tatje, City of Portsmouth; Dr. George C. Bishop, City of St. Bernard; Dr. C. P. McKee, City of St. Marys; Dr. Howard C. Lisle, City of Springfield; Julius A. Pizzoferrato, City of Steubenville; Dr. J. A. Gosling, City of Tiffin; Dr. John L. Lavan, City of Toledo; J. W. Cahill, City of Uhrichsville; Dr. R. H. Good, City of Van Wert; Dr. Alfred W. Veit, City of Wapakoneta; Dr. M. T. Knapperberger, City of Warren; Dr. A. D. DeHaven, City of Xenia; Dr. H. E. Welch, City of Youngstown.

Public Health Nurses—Mrs. Leota McKee, Carliss Jones of West Union; Mrs. Avis Smith, Barbara Basinger, of Lima; Ruth Guthrie, Mrs. Inez Waldo, of Ashland; Mrs. Martha Coffland, Elizabeth Dew, of St. Clairsville; Norma Faul, of Russellville; Esther Hamann, Annay Doyle, of Hamilton; Mrs. Ellen DeHart, Mildred Keyser, of Urbana; Effie Folsom, Ella Lemmon, Marjorie Hall, Mildred Heindel, Julia Klenke, Caroline Miller, Mrs. Clara Young, of Springfield;

Martha A. Rex, of Wellsville; Estella Madden, Cora Templeton, Frances Deer, Elizabeth Folckemer, Marian G. Howell, of Cleveland; Sara E. Doner, of Defiance; Mary Ford, Alice Whittier, Veta Wynkoop, of Delaware; Katherine Lentz, Mary Riley, Nettie Witter, Olga Busch, of Sandusky; Fannie Howe, of Lancaster; Dorothea Gaut, of Washington C. H.; Pearl Rader, Ivora Stow, Helen Myers, Inis Morris, Augusta Condit, Mary Cessna, Mrs. Mabel C. Rarey, Maria Ryan, Lillian Snyder, Jessie Hager, Catherine Donnelly, Mrs. Helen Haughton, Edith Sharret, of Columbus; Marie McElwee, of Grandview; Abigail Stebbins, of Wauseon; Mrs. Ethel Wallace, of Gallipolis; Helen Wilkinson, Jeanette Owens, of Chardon; Mrs. Pearl Wittenmyer, Mrs. Elizabeth Smith, of Xenia; Mrs. Luetta Speice, Mary Murphy, of Cambridge; Helen Hart, of Cincinnati; Martha Laffey, of Findlay;

Helen McMahon, of Kenton; Martha Reiter, Bertha Clemmer, of Napoleon; Bernice Casey, Grace Wilson, of Hillsboro; Mrs. Margaret Weaver, Lucille Roberts, of Logan; Edith F. Myers, of Millersburg; Mrs. Harriet Hunt, Mary Ryan, Margaret McKenna, of Norwalk; Jennie Ruth, of Jackson; Goldie Clayton, of Steubenville; Ila Ward, Mrs. Theodosia Wardell, of Mt. Vernon; Bertha Shields, Velma Lattimer, Mrs. Ella Bazler, of Newark; Ruth Paddock, Mabel Wade, of Oberlin; Norah D. Abbe, of Elyria; Pauline Baker, of London; Mrs. Edna Travis, Alma Denney, Mary Brenneman, Mrs. Leta Maugans, Mabel Hastings, of Marion; Sadie Green, of Medina; Naomi Mae Owens, of Pomeroy; Clara Schumm, Mary Miller, Waveline Whitmer, of Troy; Mrs. Gertrude Gorman, of Piqua; Louise Steele, of Woodsfield; Mary Christy, Mabel Lehman, Alice Mitchell, Mary Heiland, Wakneita Johnson, Agnes Ellis, Elsie Johnson, Nellie Campbell, Thelma Hill, Lucretia Thomas, Ada Joiner, Clara Jacoba, Elizabeth Armstrong, Mae Shilt, Mary Beam, Irene Hawk, Hazel Buckles, Arie Dale, Lillian Hake, Myrtle Livingston, Genevieve Young, Alvina Lindeman, Alice Keville, Bessie Shaffer, Gertrude Fry, Mayme Ewing, Clessie Fesler, Ruanna Gordon, Clarice Maney, Audrey Smith, Mary Koons, M. E. Garland, Margery Nolte, Helen Hartzler, of Dayton; Grace E. Brady, of Miamisburg; Nadean Pace, Elizabeth Moore, Harriet Phillips, Leila Abele, of Zanesville; Lucy Craft, of Caldwell; Essie Bliss, of New Lexington; Helen Bartholomew, Charlotte Phelps, of Circleville; Mrs. Grace Beckwith, of Ravenna; Winifred Cole, of Kent;

Mary Ewalt, Maude Spence, of Eaton; Ruth Hursh, Helen Hayden, Lucille Lindsey, Edith Zook, of Mansfield; Gertrude Meyers, Helen Doll, Mabel Green, of Fremont; Mrs. Georgia Sikes, Goldie Young, of Portsmouth; L. Grace Walter, of Tiffin; Elizabeth Weigand, Mrs. Mary Schulte, Margaret Offenbacker, of Sidney; Flora Booth, of Akron; Mrs. Oather Scott, of Barberton; Mrs. Lela Price, of Dover; Olive D. Sinkey, of Richwood; Elizabeth Hutson, of Marysville; Mary Connelly, Mrs. Bernice Mapes, of Van Wert; Helen D. Greene, of Bryan; Mae L. Tisdale, of Montpelier; Loneta Campbell, Wauseon; Mrs. Clara Coburn, Miss Helen Felkner, Miss Inez Gilliland, Miss Harriet Luce, Miss M. Florence Tallman, of Columbus; Miss Mabel Smith, of the State Department of Public Welfare staff; Miss Ethel Snyder and Miss Myrna Kilgore, of the State Commission for the Blind.

Guests—Mrs. M. D. Ailes, Akron; L. H. Allwardt, Chillicothe; James Clendenning, Cadiz; Mrs. W. N. Goodwin, Hamilton; Izabel Boughan, Hamilton; C. L. Hebderson, Massillon; C. R. Hixson, Johnstown; Dr. A. H. Hixson, Johnstown; Flora Howe, Lancaster; Dr. E. G. Horton, Columbus; E. E. Jackson, Columbus; Maurice Langan, Columbus; Dr. R. F. Leslie, Cleveland; Mrs. R. L. Mansell, Medina; R. L. Marlow, Athens; H. E. Miller, Washington, D. C.; Dr. C. A. Neal, Columbus; Dorothy Rose, Zanesville; Mrs. J. B. Poling, Lima; H. T. Underhille, Akron; Lula Craig, Tiffin; LaDora White, Portsmouth; Dr. Kendall Emerson, New York City, Dr. Allen W. Freeman, Baltimore, Md.; Dr. W. I. Jones, Columbus; Dr. H. M. Platter, Columbus; Dr. John E. Monger, Columbus, Mrs. Elizabeth P. August, Columbus; John McSweeney, Columbus; C. E. Hazen, Zanesville; B. F. Renkert, Kent; Dr. G. S. Burnett, Wellsville, and J. M. Montgomery, Piqua.

Ohio Child Health Conference Scheduled for January 21 and 22

Tentative plans and arrangments have been completed for the Ohio follow-up of the White House Conference on Child Health and Protection which will be held in Columbus, January 21 and 22, at the call of Governor George White.

At the conclusion of the White House Conference in November, 1930, follow-up conferences were recommended in the several states to carry out so far as feasible and practical recommendations and suggestions of the White House conference.

Several such conferences have been held in some of the states at which programs of activity for child health and welfare were outlined and set into motion.

About two months ago, Governor White took the first step toward the holding of an Ohio follow-up conference by appointing a general committee on arrangements for the forthcoming meeting. This committee is composed of A. C. Crouse, Cincinnati, former secretary to Governor White and prominently associated in welfare activities in that city, as chairman; State Director of Health H. G. Southard, State Director of Public Welfare John McSweeney, and State Director of Education B. O. Skinner. Miss Hannah L. Protzman of the Ohio Institute was named secretary of the committee.

Tentative plans for the conference call for registration of delegates on Thursday morning, January 21, at the Deshler-Wallick Hotel, to be followed by a general session Thursday afternoon in the main ballroom of the Deshler-Wallick; an inspirational meeting, open to the public, at Memorial Hall, Thursday evening; a general session Friday morning, January 22, at the Deshler-Wallick, to be followed by a luncheon and a general session in the afternoon at the same hotel.

Invitations to send official representatives to the two-days conference have been sent to official and non-official groups and organizations in Ohio, interested in health, welfare and educational questions and activities generally, and all agencies especially interested in social and health problems pertaining to children.

Honorary vice chairmen who will preside at sessions of conference are: Dr. J. H. J. Upham, dean of the College of Medicine, Ohio State University, representing the section on child health; John Eisenhauer, superintendent of the Cleveland Boys' Farm and former president of the Ohio Welfare Conference, representing the section on child welfare, and Dr. Charles S. Berry, Department of Education, Ohio State University, representing the section on child education.

Council, At Last Meeting in 1931, Acts on Many Subjects—Annual Meeting Plans, Constitutional Questions, Health Examinations, Policy Matters, Economic Problems and Budget

COUNCIL MINUTES

The Council of the Ohio State Medical Association met in the headquarters, Columbus, at 1:00 P. M., on Sunday, December 13, 1931.

The Officers and Councilors present were: Drs. Houser, Platter, Beer, Caldwell, Huston, Klotz, Hein, Cummer, Davidson, Shanley, Brush, Seiler, Goodman; Dr. Southard, State Director of Health; Dr. Alcorn, Chairman, and Dr. Upham, member, of the Policy Committee; and Executive Secretary Martin and Assistant Executive Secretary Nelson.

The minutes of the Council meeting held on October 4, 1931, (published on pages 885-888, inclusive, of the November, 1931, issue of *The Journal*) were read and on a *motion*, *seconded* and *carried*, were *approved*.

PLANS AND ARRANGEMENTS FOR 1932 ANNUAL MEETING

Dr. Platter, Chairman of the Council Program Committee, reported on the meeting of his Committee, held on the morning of this day, including plans for co-ordinated symposia of forty-five minutes each, from each of the three class A medical schools in Ohio; The School of Medicine, Western Reserve University—on the subject of Pediatrics, perhaps including a study of the effect of ultra-violet radiation from every-day illumination; College of Medicine, University of Cincinnati—on serological treatment, general vaccine therapy from the standpoint of medicine, surgery, and pediatrics; and College of Medicine, The Ohio State University—on studies in pathology and newer methods in therapy, applicable to general practice.

The Chairman also reported tentative re-arrangement for the 1932 Annual Meeting program as follows: Opening General Session on Tuesday morning, May 3, immediately followed by first session of the House of Delegates; Organization Luncheon on Tuesday noon, instead of Wednesday noon, as heretofore; the six Scientific Section Sessions on Tuesday afternoon; a General Session for the annual addresses of the President and President-Elect, perhaps with an additional speaker, on Tuesday evening; the six Scientific Sections on Wednesday morning, May 4; the General Scientific Session from 1:00 P. M. to 3:30 on Wednesday afternoon for the Symposia presented by the three Ohio medical schools; the final session of the House of Delegates, starting at 3:30 P. M.; arrangements for a session, if any, on Wednesday evening still under consideration by the Committee.

Dr. Caldwell, a member of the Program Committee, and Dr. Goodman, Secretary of the Committee, also discussed some of the plans of the Committee. Dr. Goodman raised the question of a possible change in the time of year for the Annual Meeting (not in 1932) for subsequent years.

Upon *motion* by Dr. Caldwell, *seconded* by Dr. Klotz, *and carried*, the Executive Secretary was instructed to prepare on behalf of the Council a resolution to be submitted for consideration of the Delegates at the 1932 Annual Meeting to change the Annual Meeting in 1933 from May to some time in the Fall, thus bringing the question to the House of Delegates for decision. It was further decided that following the publication of this intention, comments might be received from members of the Association, and that further consideration be given this question at the next Council meeting.

Dr. Platter called attention to the fact that the Program Committee had been giving much thought to the set-up and arrangement of the Annual Meeting and the character of the program, following the action of the Council in adopting report of his committee at the meeting on July 12, 1931. He referred to the fact that in that report, adopted by the Council, was the contemplated submission to the House of Delegates at the next Annual Meeting of proposed amendments for the separation of several present scientific sections and for the creation of additional sections with the idea that sections might be limited to one or more sessions each, instead of two sessions as has been under the present arrangements (pages 649 and 650 of the August, 1931 issue of *The Journal*).

Upon *motion* by Dr. Platter, *seconded* by Dr. Cummer, and *carried*, the Council *repealed* its action of July 12, just referred to in the preceding paragraph, relative to any contemplated increase in the number of sections.

Upon *motion* by Dr. Caldwell, *seconded* by Dr. Cummer, *and carried*, the Executive Secretary was instructed on behalf of Council to draft proposed amendments to Chapter III of the By-Laws of the State Association (defining the six scientific sections) to place in the hands of the Council the authority to determine for each Annual Meeting the division of the scientific program and the option as to whether or not section sessions would be held, thus providing more flexibility and more ready adjustment to the wishes of the membership

in arrangement of the Annual Meeting programs from time to time.

Dr. Huston, Chairman of the Council Committee on Arrangements, reported on the expression of the sentiment by members of the Montgomery County Medical Society in regard to features of entertainment during the next Annual Meeting of the State Association in that city. Attention was called to the fact that Dr. F. K. Kislig, President of the Montgomery County Medical Society, Dr. A. W. Carley, General Chairman of the local Committee on Arrangements, and Dr. C. H. Tate, Chairman of the local Entertainment Committee, all of Dayton, were present in the building, and would appreciate an opportunity of presenting their viewpoint to the Council. The Council invited them to appear and present their ideas.

A number of motions were submitted, amended, and withdrawn. There was considerable discussion by various members of Council, several of whom expressed their opinion as not favoring a banquet during the Annual Meeting in accordance with the sentiment expressed by the Council at its last meeting (page 885, November, 1931, *The Journal*), but that if the majority of the Montgomery County Medical Society desired to hold a banquet, that they had no particular objection to such a function. In view of the fact that the Council could not determine positively, from the discussion submitted, the sentiment and action of the Montgomery County Medical Society on this matter, upon *motion* by Dr. Klotz, *seconded* by Dr. Davidson, *and carried*, the Council decided to leave the question of a banquet and other related entertainment, together with all responsibility, financial and otherwise, entirely with the Montgomery County Medical Society, which when determined by that Society must be reported to the President of the Ohio State Medical Association, on or before February 1, 1932 in order that the Program Committee, with power to act, might adjust the Program to either contingency—a banquet, or no banquet.

ACTION ON CONSTITUTIONAL CONFORMITY

Dr. Cummer, the Chairman of the Council Committee on Constitutional Conformity reported on the meeting of his Committee, held on the evening preceding this meeting, and on detailed correspondence with his Committee since the last Council meeting. He reported much progress and recommended for official approval by the Council at this time of the Constitutions and By-Laws of the following component county medical societies submitted to the Committee for consideration since the last Council meeting:

Ashland County Medical Society
Clermont County Medical Society
Columbiana County Medical Society
Fulton County Medical Society
Gallia County Medical Society
Guernsey County Medical Society
Henry County Medical Society
Licking County Medical Society
Mercer County Medical Society
Morgan County Medical Society
Morrow County Medical Society
Ottawa County Medical Society
Paulding County Academy of Medicine
Putnam County Medical Society
Seneca County Medical Society
Shelby County Medical Society
Union County Medical Society
Vinton County Medical Society
Washington County Medical Society
Wayne County Medical Society
Wyandot County Medical Society.

On *motion* by Dr. Seiler, *seconded* by Dr. Hein, *and carried*, the Council approved as official the Constitutions and By-Laws of the foregoing societies as recommended by the Committee.

The Council Committee on Constitutional Conformity through Dr. Cummer, then recommended for final approval the Constitutions and By-Laws of the following component societies which have been completed and adopted by those societies since the last Council Meeting, and which were previously approved conditionally by the Council, subject to adoption:

Columbus Academy of Medicine
Erie County Medical Society
Logan County Medical Society
Madison County Medical Society
Montgomery County Medical Society
Summit County Medical Society
Tuscarawas County Medical Society.

On *motion* by Dr. Brush, *seconded* by Dr. Huston *and carried*, the Council approved as official the Constitutions and By-Laws of the foregoing societies, as recommended.

The Committee on Constitutional Conformity recommended for conditional approval, subject to adoption of necessary amendments already prepared and ready for action, the Constitution and By-Laws of the following component societies:

Fairfield County Medical Society
Lucas (Academy of Medicine of Toledo and Lucas County)
Scioto (Hempstead Academy of Medicine).

Upon *motion* by Dr. Hein, *seconded* by Dr. Davidson, *and carried*, the Constitutions and By-Laws of the foregoing component societies were conditionally approved, as recommended.

Dr. Cummer expresed appreciation to the Councilors and to the Officers and members of the component societies in their respective districts for their splendid cooperation, the result of which is shown in the action just taken by the Council in approving constitutions of a number of the component societies. Dr. Cummer then analyzed and summarized by Councilor Districts the complete status of constitutions, showing that only nine component county societies have yet failed to take some action on the adoption of constitutional provisions, in accordance with the provisions and requirements of the Constitution and By-Laws of the State Association, and that only a few com-

ponent societies, the constitutions and by-laws of which were conditionally approved, have failed to take final action.

THE QUESTION OF A WOMEN'S AUXILIARY

Dr. Houser, the President, presented to the Council a communication from Mrs. A. A. Ahn, Columbus, Ohio, requesting a hearing before the Council of representatives from the National Women's Auxiliary. Dr. Houser, also submitted to the Council his reply to Mrs. Ahn, as well as a communication from Stark County, soliciting a hearing on this question. The President reviewed briefly the Council action on this matter during the past seven and a half years, and referred to the minutes of Council meetings on several occasions. Dr. Upham discussed the question at some length, and referred to the meetings and action of the National Auxiliary at Annual Meetings of the American Medical Association, and in other states.

Upon *motion* by Dr. Cummer, *seconded* by Dr. Platter, *and carried* by vote of 4 to 3, the Council decided to grant a fifteen minute hearing to the women proponents of this matter at the next Council meeting, the exact time to be determined by the President.

PERIODIC HEALTH EXAMINATIONS

The President reported on a meeting of the Periodic Health Examinations Committee, held in Columbus, on November 15, and on the activities of the Committee to date. The President read the following from the minutes of the Committee meeting:

> "Dr. Rowland, Chairman, suggested, in view of the valuable ideas submitted by the members of the Committee, that this Committee recommend to the Council a constructive five year plan, which should be logically continuous but in the nature of a restrained and conservative campaign to the members of the profession themselves, including communications and especially timely and well prepared articles in the *Journal*, at least brief mention, in each issue of *The Journal*. He also recommended that the Committee prepare an article as one of the first steps for publication in *The Journal*, bringing up to date the development of the periodic health examinations movement, this to be supplemented by Presidential support, reminders by the Councilors in their visits to their county societies, editorial comment, and other means of approach, including an early communication from the Committee to the secretaries of each society urging that a meeting be devoted to the subject in the near future or at least during the current winter, or before next summer's vacation from regular meetings, and that county societies be encouraged to form health educational committees in cooperation with local health departments. He pointed out that such committees would have valuable suggestions from the educational committees already in existence in the Cleveland Academy and elsewhere.
>
> "On *motion* by Dr. Hendershott, *seconded* by Dr. Hagen, and *carried*, the foregoing summary of suggestions were adopted and authorized to be submitted by the President on behalf of the Committee to the Council at its next meeting."

On *motion* by Dr. Brush, *seconded* by Dr. Seiler, *and carried*, the Council approved the proposals recommended by the Committee on Periodic Health Examinations, with a substitution of the wording "consecutive" in place of the words "five year" preceding the word "plan" referred by the Committee.

MEDICAL ECONOMICS QUESTIONNAIRES

Dr. Upham reported to the Council on conferences in Chicago with officials of the American Medical Association on proposed questionnaires on a medical economic survey, based on the request of Council for such conferences at its last meeting (page 886 of the November, 1931, issue of *The Journal*). In his report, Dr. Upham stated that the matter had been satisfactorily adjusted, that multiple questionnaires would not be sent out to the county medical societies in Ohio, and that the Medical Economics Committee, the Policy Committee, and the headquarters office of the State Association, would endeavor to cooperate as fully as possible in assembling authoritive information on numerous medical economics questions for the Bureau of Medical Economics of the A. M. A.

PENDING VETERANS' LEGISLATION

Dr. Upham reported on a series of conferences which had been arranged by the Committee on Legislative Activities of the A. M. A., and the Legislative and Rehabilitation Committee of the American Legion to discuss policies and proposals on future veterans' legislation, as contemplated under the Shoulders' Resolution, adopted by the House of Delegates of the American Medical Association, at its last Annual Meeting. He told of a conference already held on November 19, from which much encouraging progress had been reported. He discussed plans for further conferences on a national basis, and in many of the states, for the purpose of creating more complete mutual understanding and for the adoption of a harmonious and concerted viewpoint on these questions.

This subject was referred to in the last Council meeting (page 887 of the November, 1931, issue of *The Journal*, and a detailed article on the general problem was published in the August, 1931, issue of *The Journal*, pages 643-646, inclusive).

PROPOSED OSTEOPATHIC SURVEY

On behalf of the Policy Committee, Dr. Upham reported on conferences with officials of the Council on Medical Education and Hospitals and other officials of the A. M. A., including members of the Board of Trustees, on the possibility of an authoritative inspection of osteopathic schools. Reference was made to the action and efforts of the Policy Committee of the Ohio State Medical Association, and correspondence between the Com-

mittee and the Council on Medical Education and Hospitals. He reported on a subsequent conference with officials of the Carnegie Foundation for Medical Teaching. He stated that a survey on medical education under the auspices of that organization was now under way in California and that the osteopathic school in that state might be included in the survey. He stated that officials of the Carnegie Foundation were interested in a general survey throughout the country, and that as soon as the economical situation was clarified that there were encouraging prospects for such a general survey as suggested. He referred to the previous discussion on this matter with special reference to the action of the Council at its latest meeting (pages 887 and 888 of the November, 1931, issue of *The Journal.*

CRIMINOLOGIC INSTITUTE

Dr. Alcorn, Chairman of the Policy Committee, reported on correspondence and conferences, and discussed possible legislation for a criminologic institute or crime detection bureau in Ohio. He referred to the action and report of Committee of the American Medical Association on Medical-Legislative Problems, and told of several conferences he had had with the State Director of Welfare. He emphasized the need of a physician-pathologist to coordinate and systematize scientific investigation of crime in which medical problemes are involved. He discussed the matter in connection with the coroner system now in effect in Ohio. He stated that his Committee would continue to confer with other institutions, individuals, and groups on possible legislation and called attention to this matter as discussed at the last meeting of the Council (page 887 of the November, 1931, issue of *The Journal.*)

BUDGET FOR 1932

The Council went into executive session at this point, and the Auditing and Appropriations Committee, through Dr. Goodman, submitted the following report and recommendations for the proposed budget for the Ohio State Medical Association for the calendar and fiscal year of 1932.

REPORT AND RECOMMENDATIONS OF THE COMMITTEE ON AUDITING AND APPROPRIATIONS

On account of the uncertainty of economic conditions, the development of new problems, and the increased need of medical organization to serve and protect its members, individually and collectively, as well as to promote and support those things necessary for the public health and public welfare, this Comimttee is confronted with unusual difficulties in preparing and submitting to the Council for consideration, modification and final approval the budget for our State Association for the calendar and fiscal year of 1932.

In considering the needs and requirements for the coming year, it is proper to review briefly the situation of the year now closing. Due to careful supervision by this Committee and efficient management in our headquarters office, the disbursements for the current fiscal year of 1931 have been kept within the authorized budget. Every precaution and safeguard was observed to protect our accumulated balance. Part of the funds which have been on time deposits in banks were transferred to government bonds. Funds that would be required before the end of the year were placed on time deposits or certificates of deposit, from which source the Association benefited by accrued interest until such funds were needed.

It has been the earnest purpose of this Committee, as well as its official function, to see that the funds of our Association were not only conserved and protected, but that they were effectively and judiciously expended for the benefit of the membership.

In accordance with custom, this Committee employed a certified, public accountant to audit the records of all financial transactions of the Association for the calendar year which constituted part of the Annual Report of this Committee. A similar complete audit will, of course, be made after the end of the present fiscal, calendar year.

All bills were carefully examined and approved before vouchers were issued for payment. All the routine and mechanical bookkeeping devices necessary for the accurate and efficient maintenance of records have been utilized. No expenses have been incurred or bills paid unless authorized in advance by this Committee, and no bills were paid until approved by this Committee.

Our accumulated balance for this year will be slightly less than that of last year, due primarily to a slight decrease in advertising (thus requiring more State Asosciation funds for *The Journal*), and the fact that we secured little or no profit from the exhibits at the last Annual Meeting, on account of the facilities and situation in Toledo, whereas, in recent years, there had been a profit from this source of upward of a thousand dollars, each year. However, our income over expenditures for 1931 will probably be over $2,000 to add to our reserve.

In view of the uncertainty of advertising revenue to *The Journal* for the coming year, the possibility of a reduced income from exhibit space at the Annual Meeting, and other problems, this Committee believes that we should endeavor to cut our budget somewhat below the budget authorized for the year now closing, at least temporarily, with the idea of not utilizing any of our reserve balance until, or unless, absolutely necessary.

It should be emphasized, however, that the present changing conditions have multiplied the problems confronting medical organization, and have increased the already heavy routine of our headquarters office. As a matter of fact, the increase in detail work would ordinarily justify us in increasing our staff. Such an increase, however, is not recommended by this Committee at this time. We must, of course, maintain our organization machinery to the greatest possible efficiency to meet the complex and sudden problems, and to render adequate service to our membership.

With the approval of this Committee, the Executive Secretary has secured estimates and held a number of conferences during recent weeks in an effort to anticipate and, if possible, minimize some of the routine expenses, including printing, office supplies, etc., for the coming year, and has succeeded in making a very satisfactory contract on printing; including *The Journal* for 1932.

This Committee believes, that, at least for the time being, we are justified in submitting a budget for 1932 which is approximately $4,300.00

less than the budget which was approved for 1931. This does not contemplate any reduction in salaries, nor does it, of course, contemplate any increase. As conditions improve and the situation is clarified, or if emergencies arise, this Committee may feel justified in submitting to the Council at a later meeting consideration for increased expenditures with possible utilization of some of our reserve.

The accompanying proposed budget for 1932, with a comparative list of the budget authorized for, and appropriated for 1931 in parallel columns is listed herewith:

	Recommended 1932Appr'n.	1931 Appr'n.
Ohio State Medical Journal	$8,000	$10,000
Medical Defense	4,000	5,000
Committee on Public Policy	1,000	1,500
Executive Secretary, Salary	6,600	6,600
Executive Secretary, Expense	800	1,000
Ass't Executive Sec'y, Salary	3,850	3,850
Ass't Executive Sec'y, Expense	200	300
President, Expense	300	300
Treasurer, Salary	300	300
Council, Expense	700	800
Annual Meeting	500	500
Auditing and Appr'n	100	200
Misc. Committee Expense	600	700
Stationery and Supplies	700	800
Postage and Telegraph	700	800
General Counsel	2,100	2,100

Auditing and Appropriations Committee.

S. J. GOODMAN, M.D., *Chairman*, Columbus
C. L. CUMMER, M.D., Cleveland
E. M. HUSTON, M.D., Dayton.

On *motion* by Dr. Goodman, *seconded* by Dr. Seiler, *and carried* the Council adopted the foregoing report, and approved and authorized the budget as recommended to govern expenditures of the State Asociation for the calendar and fiscal year of 1932.

MISCELLANEOUS

In the absence of Dr. Goodman, at this point, Dr. Cummer, Secretary Pro-Tem., read a communication addressed to the Ohio State Medical Association from the Industrial Health Conservancy Laboratories by Dr. Carey P. McCord, Cincinnati, Medical Director, requesting the publication of a series of articles by himself in the *Ohio State Medical Journal* covering the diagnosis of compensable occupational diseases in Ohio under the Workmen's Compensation Law, and requesting that these articles be reprinted in a booklet for distribution to the physicians of the State. This proposal and request was discussed by several Councilors. On *motion* by Dr. Davidson, *seconded* by Dr. Seiler, *and carried*, action on this matter was deferred.

Dr. Davidson reported briefly and verbally on the Annual Ohio Welfare Conference held in Akron, October 6-9, and stated that he hoped to be in position to submit a written report to the Council at a later meeting.

Dr. Southard, State Director of Health, reported on plans and program for the State Conference on Child Health and Protection which is to be held in Columbus on January 21 and 22. He also reported on the highlights of the Twelfth Annual Conference of Ohio Health Commissioners, held in Columbus, November 18, 19 and 20 (detailed news of which is published in the January, 1932, issue of *The Journal*).

Dr. Platter submitted for the consideration of the Council a communication from Benj. W. Van Riper, representing the Amerop Travel Service, Inc., requesting that the *Ohio State Medical Journal* carry inserts to be furnished by him, advertising clinic tours to Europe for the summer of 1932 which would include the Centennial Anniversary Meeting of the British Medical Association, such tours to be announced as being under the organization auspices of the *State Medical Journals* of the states in which such advertising inserts appear, the arrangement to be that *The Journal* would receive a specific percentage on the business secured in the nature of passengers for such tours among the physicians in Ohio. This proposal was discussed by a number of Councilors. On *motion* of Dr. Seiler, *seconded* by Dr. Hein, *and carried*, the Council reaffirmed its action at the May 11, 1931 (page 487 of *The Journal* for June, 1931) in instructing the publication committee to accept advertisements in the *Ohio State Medical Journal* only at the regular advertising rates.

Dr. Cummer submitted for the consideration of the Council the suggestion that the Constitution and By-Laws of the State Association be amended to provide for four Councilors-at-Large, two to be elected each year, for terms of two years, and no two to be from the same Councilor District. He pointed out that with the numerous involved and difficult problems confronting the medical profession, at this time, that the Council should have the advantage of the training and experience of additional members in considering and solving some of the confusing questions coming before the Council. He suggested that if members of Council expressed themselves as favoring such a proposal, that it should be prepared and submitted for the consideration of the House of Delegates at the next Annual Meeting.

A report on membership showed: 5482 members to date for 1931 compared with 5514 on the same date last year, which was the total for that year—699 members paid in advance for 1932 as compared with 857 paid in advance on the same date for 1931.

The Council adjourned to meet early in March at the call of the President.

S. J. GOODMAN, M.D.,
Secretary of Council.

C. L. CUMMER, M.D.,
Secretary Pro-Tem, in the temporary absence of Dr. Goodman.

Questions That Were Asked of Physician Applicants for Licenses by the State Medical Board in the December Examinations

Forty-one medical school graduates took the December examinations given in Columbus, December 8, 9 and 10, by the State Medical Board for those seeking licenses to practice medicine and surgery in Ohio.

Results of the examinations will be announced at the next meeting of the Board, January 5.

In addition, the following seeking certificates to practice in their particular fields were examined: 10 osteopaths, 10 chiropractors, 6 mechanotherapists; 5 electrotherapists; 1 cosmetic-therapist, and 22 masseurs.

The questions asked in the examinations given the applicants for licenses in medicine and surgery were as follows:

CHEMISTRY

1. How can you detect arsenic in a case of suspected poisoning?
2. Give chemical reasons why diabetics should abstain from starchy foods.
3. What is the value of fats as foods?
4. Give chemical formula of urea.
5. What is the strength of physiologic salt solution?

PHYSIOLOGY

1. State the current views of the functions of the spleen.
2. Explain the optical factors involved in the judgment of size, distance and form of visible objects.
3. What are the end products of digestion?
4. Give in detail an example which illustrates the difference in the physiological action of the sympathetic and para-sympathetic nerves.
5. Discuss the relation of the "basal state" to bodily function.
6. What are the physiological accompaniments and consequences of hyperventilation?
7. What would be the physiological effects of gradually increasing the intracranial pressure?
8. Discuss the metabolism of calcium with particular reference to
   (a) The daily requirement
   (b) Absorption and excretion
   (c) The factors influencing bone-formation.
9. Discuss "oxygen debt" and its significance for muscular work.
10. What are the effects of establishing an open communication through the chest wall between the pleural cavity and the exterior?

ANATOMY

1. Give the origin, function and distribution of the pneumogastric nerve.
   Name the opening in the skull through which it passes.
2. Name the veins of the upper extremities.
3. Describe the pulmonary artery.
   Give origin, distribution and branches.
4. What cavities do the palate bones assist in forming?
5. Mention the origin, insertion, action and nerve supply of the trapezius muscles.

PATHOLOGY AND HYGIENE

1. Discuss the technic of obtaining specimens for blood Wassermann Test, blood N. P. N., blood culture and blood sugar estimation.
2. Describe the blood picture in purpura hemorrhagica and pernicious anemia and discuss indications of improvement as shown in the blood examinations.
3. Discuss the pathology of acute cholecystitis with probable terminations.
4. Describe the pathology of an enlarged liver:
   (a) Secondary to cardiac decompensation
   (b) In hepatic cirrhosis.
5. Describe the pathology of aortic regurgitation and secondary changes in the heart.
6. Name three consequences of ingesting improper meat. How recognize them?
7. Discuss the dangers of the community swimming pool.
8. Discuss the proper ventilation of
   (a) a school room
   (b) a work shop
   (c) a bedroom.
9. What is meant by vital statistics?
   Outline the duty of a practitioner in this state activity.
10. What is the significance of a fixed low specific gravity of the urine? What further tests would you make in confirmation?

MATERIA MEDICA

1. What are the usual indications for the use of diuretics?
2. Classify emetics and name a drug preparation of each class giving dosage and mode of administration.
3. From what is codein derived?
   Give dose and effect upon respiration.
4. Enumerate the contra-indications to the therapeutic use of digitalis.
5. Name two hypnotics in common use and give dose of each.
6. Compare the action of aconite and digitalis.
7. Give action and indication for the use of agar-agar.
8. Name three fluid extracts and three tinctures and give dose of each preparation.
9. What dangers are attached to the use of insulin?
   Give dose and how administered.
10. What remedies are employed to correct anemic conditions?
    How are they used?

MATERIA MEDICA (Homeopathic)

1. What are the skin symptoms of Arsenicum Alb?
2. Describe the chest conditions for which you would give Bryonia.
3. Does Phosphorus act on the nervous system? If so, how?
4. Describe the headache of Gelsemium.
5. What are the gastric symptoms of Lycopodium?
6. What is a Nosode? Name four.
7. Differentiate cactus and adonis verenales in heart conditions.
8. What is the action of Hydrastis on Mucous Membranes?
9. What are throat symptoms of Belladonna?
10. What is Merc Sol?

SURGERY

1. Name the causes of sub-diaphragmatic abscess.
   Differentiate it from abscess of liver and empyema of lower right thorax.
   At what point would you operate to drain?
2. A male patient enters the hospital suffering from excruciating spasmodic pain in the left lower iliac area, this pain fades and deepens, becoming progressively worse, requiring morphine 1/3 to 1/2 and atropine 1/150 to 1/100 before relief is obtained, examination reveals urine negative to blood, there is no hernia, the bowels have been regular and there is no evidence of bloody mucus in the stool. Give a tentative diagnosis.
3. A patient enters the hospital as an emergency: examination reveals a large man weighing 300 pounds, having a systolic pressure of 225, labored respiration, urine positive to blood and sugar—retention of urine—history of self catheterization and part of a rubber catheter broken off and within the bladder. How would you proceed to treat the same? Give type of anesthetic used, if any. How would you avoid operative shock?
4. A patient is brought to you for treatment of Potts fracture of two days standing, the leg is extremely swollen and out of alignment, there has been no tenderness or pain accompanying the injury. What condition would you suspect? Outline your treatment.
5. For what conditions would you do a resection of the elbow joint?
6. Differentiate between a stone in the common duct and cancer of the head of the pancreas.
7. Discuss the symptoms and clinical course of acute dilatation of the stomach. Outline treatment.
8. Name the sequelae resulting from severe uterine cervical lacerations.
9. Name in the order found the most frequent locations that malignancy attacks the intestinal tract.
10. Name at least six causes of chronic ulceration.

DIAGNOSIS

1. Differentiate between Pyelitis and Typhoid Fever in a girl of six years.

2. What are the different characteristic features found in
(a) Agrandulocytosis (b) Pernicious anemia.
3. A young man enters the hospital complaining of severe headaches—loss of vision—loss of memory—increasing weight—and tendency to weep on slight provocation. What line of examination would you institute?
Give a tentative diagnosis.
Name what additional findings you would expect to confirm your diagnosis.
4. Upon what signs and symptoms would you make a diagnosis of multiple myeloma?
5. In what positions would you expect to find the bone fragments in the following simple fractures:
(a) Fracture o fthe humerus, three inches below the neck
(b) Of the femur, five inches above the knee joint.
6. Give early differential features between infantile paralysis and spinal meningitis.
7. Differentiate between the following types of gangrene:
(a) Dry (b) Moist (c) That produced by Bacillus Welchii.
8. Give the causes and symptoms in the early stages of Parkinsons disease.
9. In sarcoma of the testicle where would you expect to find the first metastatic tumor?
10. In what conditions would you expect to find the following:
(a) Increased metabolic rate (b) Decreased metabolism.

OBSTETRICS

1. Give symptoms of abortion, threatened and inevitable, and management of each.
2. Give three most important diagnostic points on the fetal head. How used to determine presentation and position?
3. What are some of the causes of premature rupture of the membranes? How does it influence the progress of labor?
4. Name and describe the five movements in the mechanism of labor in an L. O. A. position.
5. What are the most serious complications met with in breech presentation?

PRACTICE

1. Discuss essential hypertension and the relative indications of
(a) high systolic (b) high diastolic hlood pressure.
2. Discuss the etiology, possible results and treatment of enlarged glands of the neck in a child of six years.
3. Name four common eruptive diseases of childhood; describe character of eruptions of each, its period of appearance and method of disappearance.
4. Name some of the local and systemic conditions for which, as a general practitioner, you would advise tonsillectomy in a young child.
5. How would you recognize tuberculous pleurisy with effusion and give treatment.
6. What are the symptoms of intestinal impaction? Give treatment.
7. What is usual cause of a spontaneous pneumothorax? How would you recognize the condition and give treatment?
8. Describe the symptoms of complete heart-block. Give cause and treatment.
9. What are the dangerous possible developments in adenomas of the thyroid? What would be your advice to patient with such condition?
10. Discuss two clinical syndromes indicating disease of pituitary body, with treatment of each.

SPECIALTIES

1. Discuss infantile eczema and its treatment.
2. Differentiate catarrhal conjunctivitis, follicular conjunctivitis and gonorrheal conjunctivitis.
3. Discuss the positions and relations of the submaxillary gland.
4. Does one attack of diphtheria confer immunity? How would you deal with a diphtheria carrier?
5. Is there any relation between sinus infection and so-called bronchial asthma? Give reason for your answer.

The Academy of Medicine of Lima and Allen County has announced that it has secured Professor Julius Bauer of Vienna to deliver the fourth annual series of post-graduate lectures sponsored by the Academy and to be given the third week of September, 1932. Dr. Bauer expects to be in America for several months next year for lecture work. Information concerning the Lima meeting may be obtained from Dr. P. I. Tussing, 507 W. Spring Street, Lima.



John A. Burnett, M.D., Hamilton; Eclectic Medical College, Cincinnati, 1902; aged 52; member of the Ohio State Medical Association and the American Medical Association; died November 28 of heart disease. Dr. Burnett had practiced in Hamilton since his graduation. He served as county coroner for 15 years, and for the past nine years had been physician for the Hamilton public schools. Surviving him are his widow, one son, one daughter, and three brothers.

Claude B. Cole, M.D., Toledo; Long Island College of Medicine, Brooklyn, 1889; aged 65; member of the Ohio State Medical Association and Fellow of the American Medical Association; died November 22 of apoplexy. Dr. Cole had practiced in Toledo for 31 years. He is survived by one daughter and two brothers.

Benjamin F. Collins, M.D., Steubenville; Columbus Medical College, 1892; aged 62; former member of the Ohio State Medical Association; died November 7, following a long illness. Dr. Collins began practice with his father in Toronto, later moving to Youngstown, where he practiced for several years before locating in Steubenville. He is survived by his widow, three daughters and one son.

Thomas A. Dickey, M.D., Middletown; Medical College of Ohio, Cincinnati, 1871; aged 80; member of the Ohio State Medical Association and Fellow of the American Medical Association; died December 2. Dr. Dickey, dean of Middletown physicians, and one of the founders of Middletown Hospital and Woodside Cemetery, had practiced in Middletown for 55 years. He is survived by two sisters.

Gerry E. Emanuel, M.D., Edgerton; Rush Medical College, Chicago, 1884; aged 68; former member of the Ohio State Medical Association; died October 24. Dr. Emanuel had practiced in Edgerton for 47 years. Surviving him are his widow, one son and one daughter; and two brothers.

David J. Evans, M.D., Zanesville; Starling Medical College, Columbus, 1897; aged 56; member of the Ohio State Medical Association and the American Medical Association; died December 11 at Good Samaritan Hospital, Zanesville, of heart disease. Dr. Evans had practiced in Zanesville since his graduation 34 years ago. He was mayor of Zanesville from 1918 to 1922, and had served as city health commissioner from 1926 until his death. Surviving him are his widow, one daughter and one son.

Charles A. Fraser, M.D., Wellsville; Cleveland-Pulte Medical College, 1900; aged 56; member of the Ohio State Medical Association and the American Medical Association; died December 7 of heart disease. Dr. Fraser had practiced for 31 years in Wellsville. His widow survives him.

William Albert Galloway, M.D., Xenia; Medical College of Ohio, Cincinnati, 1890; aged 71; member of the Ohio State Medical Association and the American Medical Asociation; died November 7 after an illness of several months. Following graduation, he began practice in Xenia with his brother, the late Dr. C. M. Galloway. He was a member of the draft board during the World War. For years Dr. Galloway was president of the board of trustees of the normal and industrial department of Wilberforce University. He was president of the Greene County Historical Society which he organized in 1928, and had been actively engaged in writing a history of the Shawnee Indians in Greene County. He is survived by one son, one daughter, and one sister.

Arthur L. Gast, M.D., Prospect; Columbus Medical College, 1892; aged 70; former member of the Ohio State Medical Association and Fellow of the American Medical Association; died December 3. Dr. Gast had been a lifelong resident of Prospect, where he had practiced for 40 years. Surviving him are his widow, two daughters and four sisters.

Austin Hutt, M.D., Columbus; Starling Medical College, 1878; aged 79; member of the Ohio State Medical Association and the American Medical Association; died November 18. Dr. Hutt practiced for 33 years in Waverly before locating in Columbus 20 years ago. Surviving him are his widow, two daughters; one son; one sister and three brothers.

John K. McNulty, M.D., Sinking Spring; Cincinnati College of Medicine and Surgery, 1885; aged 75; died November 11. He had practiced in Sinking Springs for 20 years. One son and two daughters survive him.

George W. Sampson, M.D., Upper Sandusky; College of Physicians and Surgeons, Keokuk, Iowa, 1880; aged 77; former member of the Ohio State Medical Association; died November 8. Dr. Sampson began practice with his father in McCutcheonville, and six years later located in Upper Sandusky, where he was associated in practice with the late Dr. G. O. Maskey. He is survived by one daughter.

Claude Addison Tallman, M.D., Maumee; Northwestern University Medical School, Chicago, 1900; aged 53; died November 20 in Flower Hospital, Toledo, from injuries received in an automobile accident. His widow survives him.

Elmer P. Trumper, M.D., Columbus; Starling Medical College, 1889; aged 70; died November 28 of heart disease. Before his retirement, he practiced in Rushville, Fairfield County. Two daughters survive him.

Omar H. Tudor, M.D., Kenton; Miami Medical College, Cincinnati, 1875; aged 83; former member of the Ohio State Medical Association; died November 11 following an illness of three weeks. He had practiced in Kenton for 55 years, and until his retirement a year ago, was a member of the staff of McKitrick Hospital, Kenton.

Wesley Van Nette, M.D., Clyde; Northwestern Ohio Medical College, Toledo, 1890; aged 75; member of the Ohio State Medical Association and the American Medical Association; died November 5 of sarcoma. Dr. Van Nette practiced in Crawford County for fifteen years before moving to Clyde in 1904. One daughter survives him.

William Sherman Warren, M.D., Jacobsburg; Starling Medical College, Columbus, 1896; aged 54; member of the Ohio State Medical Association and the American Medical Association; died November 8 of cerebral hemorrhage. Dr. Warren practiced in Belmont County for thirty years before his retirement six years ago. He is survived by five daughters and two sons.

John Richard Williams, M.D., Carrollton; Bellevue Hospital Medical College, New York, 1881; aged 73; died November 23 of a heart attack. Dr. Williams had practiced for 50 years in Carrollton. He had served as coroner of Carroll County, member of the Carrollton board of education, and was medical advisor of the draft board during the world war. Surviving him are his widow, one daughter and one brother.

Ernest S. Wright, M.D., Conneaut; Cleveland University of Medicine and Surgery, 1895; aged 64; former member of the Ohio State Medical Association; died November 11, following a long illness. Dr. Wright opened an office in Freeport, Michigan, where he practiced until 1901 when he moved to Conneaut. He is survived by his widow, three sons and a brother.

Thomas K. Wissinger, M.D., Columbus; Starling Medical College, Columbus, 1879; aged 73; died November 19. Dr. Wissinger had practiced in Columbus since his graduation, and was formerly on the staff of Mt. Carmel Hospital, Columbus. He was the last surviving member of the class of 1879, Starling Medical College. His widow and a daughter survive him.

KNOWN IN OHIO

William H. Baldwin, M.D., Berkley, California; Jefferson Medical College, Philadelphia, 1875; aged 81; died November 25. Dr. Baldwin, a native of Tiffin, had practiced in Sacramento, California, until his retirement several years ago. He is survived by his widow and a daughter, one brother, and two sisters.

William Ellery Briggs, M.D., Sacramento, California; Cleveland College of Physicians and Surgeons, 1877; aged 78; Fellow of the American Medical Association; died November 4. Dr. Briggs received his early education at Buchtel college, now Akron University. His widow survives him.

Frank Wilson Harmon, M.D., San Diego, California; Medical College of Ohio, Cincinnati, 1881; aged 80; former member of the Ohio State Medical Association; died December 7, following a long illness. He was a brother of the late Judson Harmon, governor of Ohio for two terms. Dr. Harmon practiced in Cincinnati, and was a member of the staff at Longview Hospital until his retirement in 1917, when he moved to San Diego.

Frederic W. Haudenschield, M.D., Bentonia, Mississippi; Louisville Medical College, Louisville, Kentucky, 1891; aged 73; died November 12 in a Marietta, Ohio, hospital. Dr. Haudenschield practiced at Sardis and New Martinsville, and later moved to Washington County where he continued in practice until he moved to Mississippi four years ago. Surviving him are his widow and two daughters.

Lester Keller, M.D., Santa Monica, California; Medical College of Ohio, Cincinnati, 1883; aged 72; former member of the Ohio State Medical Association; died November 29. Dr. Keller practiced in Ironton until his retirement several years ago. His widow survives him.

Frank A. Zeller, M.D., Union City, Indiana; Ohio Medical University, Columbus, 1898; aged 61; Fellow of the American Medical Association; died November 14 at Visalia, California, after an extended illness. Dr. Zeller was a veteran of the Spanish-American War and the World War. He practiced at St. Paris, Ohio, for several years before locating in Union City. He is survived by a brother, Dr. Ward C. Zeller, of Visalia, California.



Steubenville—High tribute to the late Dr. J. C. M. Floyd, former president of the Ohio State Medical Association and dean of the medical profession in Jefferson County, was paid by the Ohio Valley Hospital Association in resolutions adopted at a recent meeting of the board of trustees of the association.

Alliance—Dr. E. B. Pierce, superintendent of the Molly Stark Sanatorium delivered a public lecture on the treatment of tuberculosis at the auditorium of the Alliance High School.

Columbus—Dr. Franklin B. Jeppesen, a member of the staff of the Lakeside Hospital, Cleveland, and Miss Dorothy M. Kitch, of this city, formerly of Emmetsburg, Iowa, were united in marriage at the Northwest Boulevard Presbyterian Church, November 18.

Cleveland—Proposals relative to psychiatric examinations of accused persons in criminal cases, for convicted criminals and before issuance of paroles to inmates of penal institutions were considered at a conference called by a joint committee representing the Cleveland Bar Association and the Cleveland Academy of Medicine. Further discussions will be held before a definite program calling for legislation on the questions considered will be drafted. Among those who took part in the conference were: Dr. Samuel C. Lind, president of the Academy of Medicine; Dr. J. E. Tuckerman, Dr. Allen D. Finlayson and H. Van Y. Caldwell, secretary of the academy; Walter L. Flory, president of the Cleveland Bar Association; Miss Marie Wing, George W. Kerr, Common Pleas Judge George P. Baer, Juvenile Judge Harry L. Eastman, Dr. Royal A. Grossman, Common Pleas Court psychiatrist; Dr. D. H. Linard, Juvenile Court psychiatrist, and Dr. H. C. Schumacher of the Child Guidance Clinic.

Columbus—Dr. Will D. Murphy is recovering from an attack of pneumonia.

Marblehead—The Civic Men's Club of Marblehead was addressed recently by Dr. Paul Hohly, Toledo.

Lewisburg—Dr. Karl W. Horn was operated on for appendicitis at the Miami Valley Hospital, Dayton.

Lima—Dr. Ralph O. Ruch, formerly of Martins Ferry and for the past two years on the staff of Charity Hosiptal, Cleveland, has opened offices in Lima.

Newcomerstown—Dr. C. A. Hanson suffered a broken left ankle when he stepped into a hole in his yard while playing football with his children.

Newark—Dr. D. A. Skinner, who had been seriously ill for several months in New York City where he had gone to take post-graduate work, has returned to Newark. He expects to be able to resume his practice in the near future.

Warren—Dr. J. D. Knox reviewed the history of medicine in an address before the local Lions' Club.

Columbus—Dr. Milton L. Goodman has completed his internship at St. Francis and Children's hospital, this city, and has opened offices here for private practice.

Toledo—Dr. Frank C. Clifford has returned from New York City where he took post-graduate work in diseases of the heart.

Wadsworth—Dr. Horatio T. Pease, formerly of Lakeside Hospital, Cleveland, has opened offices here for the general practice of medicine.

Chillicothe—Dr. Frederick R. Sims, new medical officer in charge of the U. S. Veterans' Bureau

hospital here, recently addressed the Chillicothe Rotary Club.

Akron—Nurses attending the meeting of District No. 1, Ohio State Nurses' Association, at the Akron Children's Hospital, were addressed by Dr. Walter Hoyt on infantile paralysis.

Willard—Dr. J. C. Steiner has recovered from an appendicitis operation and has resumed active practice.

Middletown—Dayton's work among crippled and handicapped children was described to the Middletown Federation of Women's Clubs by Dr. John A. Judy, Dayton.

Lima—Dr. A. C. Adams has resigned as Allen County trustee for the Lima District Tuberculosis Hospital.

Dublin—Dr. H. O. Whitaker has been re-elected mayor of this village, and Mrs. Whitaker was re-elected village treasurer.

Chillicothe—Miss Marjory McIntosh and Dr. Ernest M. Tapp, both of this city, were married November 26 at the home of the bride. Dr. and Mrs. Tapp will make their home at Los Angeles where Dr. Tapp has been appointed to the staff of the U. S. Veterans' Bureau hospital.

Columbus—Dr. I. B. Harris received scalp wounds and bruises and Mrs. Harris suffered a fractured arm in an automobile accident near Washington C. H., November 27.

Gallipolis—Dr. C. E. Holzer has purchased a Waco airplane in which he has made several trips to Chicago and other mid-west cities.

Cleveland—A new series of public health lectures has been arranged by the Health Education Foundation of the Cleveland Academy of Medicine. The first lecture in the series was given December 6 by Dr. Elliott C. Cutler, professor of surgery, School of Medicine, Western Reserve University, on "What Science Knows About Cancer". On January 17, Dr. Henry J. Gerstenberger will speak on "Why Think About Eating" and on March 20, Dr. R. W. Scott will lecture on "Fighting Death After Forty".

McArthur—Dr. and Mrs. O. S. Cox of McArthur were injured when Dr. Cox's automobile skidded and turned over between McArthur and Allensville. Dr. Cox was cut and bruised. Mrs. Cox received a broken right arm.

South Vienna—Dr. E. H. Long has been granted a private airplane pilot's license by the United States Department of Commerce.

Canton—At a recent meeting of the Canton Medical Library Society, resolutions were adopted in memory of the late Dr. Harry P. Pomerene and the late Dr. Edmund D. Brant.

Xenia—Dr. H. C. Schick, a member of the staff of the McClellan Hospital, has returned from New York City where he has been taking post-graduate work.

Cleveland—Dr. James Angus Doull, Professor of Hygiene and Public Health, School of Medicine, Western Reserve University, addressed the American Epidemiological Society meeting at Yale University on December 11, on "Tuberculous Infection in Medical Students". The following week he went to Baltimore as adviser to the John Abel Fund for Research on the Common Cold, at Johns Hopkins University.

Findlay—Dr. F. M. Wiseley, newly elected president of the Hancock County Medical Society, has returned from five months study in Vienna. Dr. J. H. Marshall, the retiring secretary of the Society, returned January 1 after six months post graduate work in Surgery in New York City.

HOSPITAL NOTES

—At a recent meeting of the staff of the Lima City Hospital, Dr. Ira Baxter was elected president; Dr. Harvey Basinger, vice president and Dr. G. E. Jones, secretary-treasurer.

—A clinic for babies of indigent parents has been opened by the Marion City Hospital.

—Mrs. Zella M. Franklin, formerly principal of the nurses' training school of the Marietta Memorial Hospital, has resigned and moved to Philadelphia. Miss Helen M. Osten has been appointed to supervise nurse activities at the hospital in addition to her duties as supervisor of the surgical department.

—Additional improvements to the U. S. Veterans Hospital, Chillicothe, have been authorized, making the total cost of the project now under way approximately $600,000. The plans call for the construction of two new ward buildings, two attendants' buildings, enlargement of the mess hall and kitchen; and enlargement of the recreation building.

—Plans have been approved for enlarging the Mahoning County Tuberculosis Hospital to increase its bed capacity by 10.

—A bequest of $35,000 for the construction of a chlidren's ward at the Chillicothe Hospital was made in the will of Mrs. Elinor McKell Mayo, Los Angeles, formerly of Chillicothe.

—Work on the interior of the new $140,000 Bucyrus Hosiptal has been started.

—Directors of service to supervise the work of 18 departments of the Cincinnati General Hospital and Tuberculosis Sanitarium have been appointed by the Board of Directors of the University of Cincinnati. Those named were:

Dr. Roger S. Morris, medical service; Dr. H. Kennon Dunham, attending staff of the tuberculosis service; Dr. Alfred Friedlander, consulting staff of the tuberculosis service; Dr. George

J. Heuer, surgical; Dr. A. Graeme Mitchell, pediatric; Dr. Henry L. Woodward, obstetrical; Dr. C. L. Bonifield, gynecological; Dr. Emerson A. North, psychiatry (acting director); Dr. Albert H. Freiberg, orthopedic; Dr. Samuel Iglauer, otolaryngological; Dr. Victor Ray, Sr., ophthalmological.

Dr. E. Otis Smith, urological; Dr. Elmore B. Tauber, dermatological; Dr. Sidney Lange, radiological; Dr. R. S. Austin, pathological; Dr. William B. Wherry, bacteriological; Dr. A. P. Mathews, biochemistry, and Dr. John P. Becker, dental.

News Notes From County Societies and Academies

First District

ACADEMY OF MEDICINE OF CINCINNATI

(H. H. Shook, M.D., Secretary)

November 2—Regular meeting, Library Union Central Building: Program: "The Relationship of the Thebesian Circulation to Heart Disease", by Dr. Joseph T. Wearn, Professor of Medicine, Western University School of Medicine, Cleveland.

November 16—Program: Symposium on Chronic Appendicitis—1. Problem of Chronic Appendicitis; 2 Clinical Diagnosis; 3. *X*-ray Diagnosis; 4. Pitfalls of Diagnosis; 5. Medical Treatment of Chronic Appendicitis; 6. Prognosis in Cases Treated Medically; 7. Indications for Operation; 8. Roads to Progress, by Drs. Henry Wald Bettman and Louis Sommer; discussion by Drs. Sidney Lange, Mark A. Brown, and Charles T. Souther.

November 23—Program arranged by the Cincinnati Urologic Society: "Clinical Data with Polycystic Kidney", by Dr. Wm. B. Braasch, Mayo Clinic, Rochester, Minn.

November 30—Program: Case Reports: 1. "Anatomy of the Female Pelvis and Perineum". Motion pictures with sound, furnished by the courtesy of the Research Department of the Petrolagar Laboratories. 2. "Carcinoma of the Larynx", with presentation of patient after successful resection of larynx. Demonstration of artificial voice apparatus, by Dr. Samuel Seltz. 3. "Banti's Disease", with presentation of patient two years after Splenectomy. Demonstration of pathologic material, by Dr. Joseph N. Ganum.

In addition to the regular program, Dr. D. C. Houser, Urbana, President of the Ohio State Medical Association, spoke on "The Benefits of Periodic Examinations".

December 7—General Session. Program: "Changing Status of the Surgical Treatment of Pulmonary Tuberculosis", by Dr. John Alexander, University of Michigan, Ann Arbor.

December 14—Surgical Section. Program: "The Treatment of Surgical Shock and Postoperative Hemorrhage", by Drs. J. Louis Ransohoff and Sidney Mendelsohn; "Intravenous Use of Gum Acacia Solution in Shock", by Drs. R. W. Good and B. E. Boyer.

December 21—Medical Section. Program devoted to the Medical History of Cincinnati, with papers presented by Drs. C. L. Bonifield, A. L. Knight, E. W. Mitchell, and J. C. Oliver. Buffet lunch was served at the close of the meeting.—Bulletin.

Butler County Medical Society met at Middletown Hospital, Thursday evening, November 12 for its annual meeting. Dr. J. A. Mackie, of Hamilton, spoke on "Hematuria", preceding a dinner at 6 o'clock, attended by 25 members. The following officers were elected for 1932; President, Dr. H. N. Ward, Hamilton; vice-president, Dr. Mabel Gardiner, Middletown; secretary-treasurer, and correspondent for *The Journal*, Dr. H. O. Lund, Middletown; legislative committeeman, Dr. W. E. Griffith, Hamilton; medical defense committeeman, Dr. Dan Skinner, Hamilton; delegate to state meeting, Dr. D. M. Blizzard, Middletown; alternate, Dr. H. O. Lund.—News Clipping.

Clinton County Medical Society held its regular December meeting at the General Denver Hotel, Wilmington, Tuesday noon, December 1. Dr. D. C. Houser, Urbana, President of the Ohio State Medical Association, was present and addressed the Society on "Medical Organization", discussing the relation of the medical profession and scientific medicine to the public, and emphasizing the value of periodic health examinations in prevention of disease. Case reports were presented as follows: "Angina Pectoris", by Dr. S. J. Ellison, West Union, and Dr. S. A. Crabtree, Martinsville; "Prolapse of Umbilical Cord", by Dr. Elizabeth Shrieves; "Esophageal Stricture treated by Gastrostomy and retrograde dilatation", by Dr. W. L. Regan; "Scarlet Fever, complicated by Mastoid Abscess", by Dr. W. B. Yoakley; "Familial Retinitis Pigmentosa", by Dr. G. K. Dennis, Wilmington; "Cesarean Section", by Dr. O. T. Sproull, West Union. Officers elected for 1932 are as follows: President, Dr. F. A. Peele, Wilmington; vice president, Dr. H. E. Gibson, Blanchester; secretary-treasurer, Dr. Wm. L. Regan, Wilmington; legislative committeeman, Dr. E. Briggs; medical defense committeeman, Dr. J. F. Fisher, Sabina; delegate to state meeting, Dr. A. C. Roberts, Wilmington; alternate, Dr. Elizabeth Shrieves, Wilmington. Guests at the meeting included Dr. Houser, Drs. S. J. Ellison, O. T. Sproull and Hazel Sproull, of West Union; Dr. J. M. Brooks, Peebles and Dr. J. G. Anderson, Fayetteville.—Robert Conard, Secretary.

Fayette County Medical Society met in regular session at 1:30 P. M., Thursday, December 3, at Washington C. H. and elected the following officers for 1932: President, Dr. A. D. Woodmansee, Washington C. H.; vice president, Dr. A. S. Stem-

ler, Washington C. H.; secretary-treasurer, Dr. James F. Wilson (re-elected); legislative committeeman, Dr. R. M. Hughey; medical defense committeeman, Dr. L. L. Brock; delegate to state meeting, Dr. Lucy Pine; alternate, Dr. Paul Craig. Dr. E. G. Horton, Columbus, gave a very interesting and exhaustive talk on "Poliomyelitis" with lantern slides, which was appreciated by all present to hear him.—James F. Wilson, Secretary.

Second District

Darke County Medical Society held its regular meeting at the Cul-Mur tea room, Greenville, on Friday evening, November 13. Following a dinner at 7 P. M. Dr. C. D. Fife, of Dayton, spoke on "Some Clinical Considerations of the Cardiac Case", and Dr. H. E. Huston, also of Dayton, discussed "Diverticulitis of Colon in Women".—W. D. Bishop, Secretary.

Greene County Medical Society held a dinner meeting at the Elks' Club, Xenia, on Thursday evening, November 5, in place of the regular monthly luncheon meeting. Dr. E. M. Huston, Dayton, Councilor of the Second District, discussed organization and policies of The Medical Association.—News Clipping.

Miami County Medical Society met on Friday afternoon, December 4, at Memorial Hospital, Piqua, for the annual business session and reports of various committees.—Program.

Montgomery County Medical Society held its regular meeting on Friday evening, December 4 at the auditorium, Fidelity Building, Dayton. The program of the evening included a symposium on "Nephritis" given by Drs. C. D. Fife and M. R. Haley.—Bulletin.

Shelby County Medical Society met Friday afternoon, December 4, at Wilson Memorial Hospital, Sidney, for its annual meeting. A very interesting paper on "Coronary Thrombosis" was presented by Dr. John Quirk, of Piqua. His paper brought out many important points, and was followed by very hearty discussion and praise. Officers for 1932, elected at the business session, are: President, Dr. A. B. Gudenkauf, Sidney; vice-president, Dr. O. O. LeMaster, Sidney; secretary, Dr. B. A. Welch, Sidney; treasurer, Dr. A. W. Grosvenor (re-elected), Sidney; correspondent for *The Journal*, legislative committeeman, and medical defense committeeman, Dr. M. F. Hussey; delegate to state meeting, Dr. A. W. Hobby; alternate, Dr. Kenneth Hauver; council, one year, Dr. V. LeMaster; two years, Dr. L. C. Pepper; three years, Dr. F. Ratterman.—B. A. Welch, Secretary.

November meeting of the Shelby County Medical Society, held at Wilson Memorial Hospital, Sidney, was addressed by Dr. A. B. Gudenkauf. His paper on "Infant Mortality" was followed by a general discussion.—News Clipping.

Third District

Allen County—The annual meeting of the Academy of Medicine of Lima and Allen County was held Tuesday evening, November 17. Officers elected for 1932, are: President, Dr. E. C. Yingling; vice president, Dr. Burt Hibbard; secretary Dr. H. L. Stelzer; treasurer, Dr. J. B. Poling; correspondent for *The Journal*, Dr. Virgil Parent; legislative committeeman, Dr. R. A. Buchanan; medical defense committeeman, Dr. E. B. Pedlow, all of Lima; delegate to state meeting, Dr. Ezra Burnett, Delphos, and alternate, Dr. C. L. Steer, Lima. An illustrated lecture on "Goiter" was presented by Dr. Norris Gillette, of Toledo, with discussion by Drs. Smead and Gardiner, of Toledo. —News Clipping.

Hancock County Medical Society held its annual meeting at the residence of Dr. J. V. Hartman, Findlay, on Wednesday evening, December 2, with Drs. Biggs and Fishell as assisting hosts. Dr. Hartman gave an interesting case report, and Dr. J. M. Firmin presented a paper on "Treatment of Empyema". The annual election of officers was held, with the following results: President, Dr. F. M. Wiseley; vice president, Dr. W. J. Fishell; secretary, Dr. H. O. Crosby; treasurer, Dr. E. J. Thomas (re-elected); correspondent for *The Journal*, Dr. Crosby; legislative committeeman, Dr. E. R. Wynn; medical defense committeeman, Dr. D. B. Biggs; delegate to state meeting, Dr. J. V. Hartman; alternate, Dr. E. J. Thomas. —H. O. Crosby, Secretary.

Mercer County Medical Society enjoyed a dinner at the Quick Service Restaurant, in Celina, on Thursday evening, November 13, followed by the regular meeting of the society at the office of Dr. D. H. Richardson. Speakers were Dr. O. P. Klotz, Findlay, councilor of the Third District, and Dr. W. W. Duemling, of Fort Wayne, Indiana.—News Clipping.

Van Wert County Medical Society held its regular meeting on Tuesday evening, December 1, at the Van Wert County Hospital, Van Wert. Dr. Miles Porter, Jr., of Fort Wayne, Indiana, spoke on "Lethargic Encephalitis", giving his experience in over fifty cases. In his address he emphasized diagnosis and terminal end results. General discussion followed. Nearly all the local membership was in attendance, and visiting physicians were present from Paulding and Delphos. —News Clipping.

Fourth District

ACADEMY OF MEDICINE OF TOLEDO AND LUCAS COUNTY

(A. F. Hancuff, M.D., Secretary)

December 4—Annual joint meeting of the Toledo Dental Society and the Academy of Medicine, at the Academy building. Program: "The Way to Health Insurance", by Dr. N. Sinai, Director, Division of Hygiene and Public Health, University of Michigan.

December 11—Section of Pathology, Experi-

mental Medicine and Bacteriology. Program: "Agranulo-Cytosis", by Dr. S. S. Hindman; "A Report of Two Interesting Rectal Cases", by Dr. J. F. Whitacre; "Ruptured Aneurism of Aortic Arch", (case report) by Dr. S. D. Zuker.

December 18—Medical Section. Symposium on Tuberculosis: "Childhood Pulmonary Tuberculosis", by Dr. H. M. Foster; discussant, Dr. M. E. Goodrich; "Adult Pulmonary Tuberculosis", by Dr. Paul Holmes; discussant, Dr. Foster Myers; "Extra-Pulmonary Tuberculosis with Particular Reference to Heliotherapy", by Dr. S. D. Giffin; discussant, Dr. B. J. Hein; "The Surgical Treatment of Tuberculosis" by Dr. W. W. Stone; discussant, Dr. R. H. Elrod.—Bulletin.

Four County Medical Society—(Defiance, Fulton, Henry and Williams Counties.)—The September meeting was held at Bryan, on Friday, the 25th, with the following interesting program: Symposium on Gastro-Intestinal Diseases: "Management of Esophageal Lesions", by Dr. E. G. Galbraith; "Diagnosis and Medical Management of Stomach and Colon Diseases", by Dr. H. H. Howe; "Abdominal Surgery in Genito-Urinary Lesions", by Dr. J. A. H. Magoun; "Surgery of the Stomach and Duodenum", by Dr. W. A. Neill; "Surgery of the Colon", by Dr. Kinsley Renshaw; "Gastro-Intestinal Neuroses", by Dr. Louis Miller. Speakers were all from Toledo, Ohio. A dinner at 6 P. M. concluded the session.

The October meeting was held at the Kettenring Golf Club House, Defiance, on Thursday afternoon, October 29. Preceding a six-o'clock dinner, attended by forty members, the following papers were presented: "Diseases of the Colon", by Dr. John P. Tucker, Cleveland; "Present Status of the Treatment of Cancer of Various Parts of the Body", by Dr. T. E. Jones, of Cleveland. The essayists presented their topics in an informal and instructive manner. The program was highly appreciated by the members present.

November meeting of the Society was held at the Wellington Hotel, Napoleon, on Tuesday, November 24. Program: "The New Nomenclature and Classification of Goiter" with a description of the general treatment. Moving pictures of general goiter interest, by Dr. Norris W. Gillette, Toledo; "Pathology of Goiter". Various types were demonstrated with lantern slides, by Dr. A. H. Schade, Toledo; "The Mental Factor in Disease, or Medical Psychology," "Endocrinology", by Dr. W. W. Beauchamp, Lima. The dinner meeting at 6 P. M. was addressed by Dr. D. C. Houser, Urbana, President of the Ohio State Medical Association.—D. J. Slosser, Secretary.

Putnam County Medical Society met Tuesday evening, December 1, at Hotel Dumont, Ottawa, for its annual dinner meeting, which was attended by approximately 50, including members and their wives. Dr. W. H. Vorbau, Lima, was the visiting speaker. The following officers were elected for 1932: President, Dr. P. D. Bixel, Pandora; vice president, Dr. H. N. Trumbull, Columbus Grove; secretary-treasurer, Dr. A. L. Fipp, Glandorf; correspondent for *The Journal*, Dr. H. A. Neiswander; legislative committeeman, Dr. H. H. Sink, Columbus Grove; councilors, Drs. B. P. Davis, J. R. Echelbarger, and Frank Light; delegate to state meeting, Dr. L. M. Piatt; alternate, C. E. Beardsley.—H. A. Neiswander, Correspondent.

Wood County Medical Society held its regular meeting at the Woman's Club, Bowling Green, on Thursday evening, November 19. The following program was presented: "Infections of the Upper Respiratory Tract", by Dr. E. C. Unckrich, of Toledo; "Diseases of the Kidneys and Ureters", by Dr. F. B. McNierney, of Toledo. Speakers for the October meeting were Drs. Magoun, Bayha, and Brown, of Toledo.—Bulletin.

Fifth District

ACADEMY OF MEDICINE OF CLEVELAND

(Clarence H. Heyman, M.D., Secretary)

December 2—Obstetrical and Gynecological Section. Program: "Prophylactic Use of Episiotomy in Primiparae", by Dr. Harry A. Gusman; (a) "Suspension of Uterus for Retrodisplacement"; (b) Vaginal Hysterectomy for Uterine Prolapse". (Talking Films prepared by Dr. H. O. Jones, Assistant Professor of Gynecology, Northwestern University).

December 4—Clinical and Pathological Section. Program: "Foreign Body in Oesophagus of a Child", by Dr. W. H. Tuckerman; "Fetal Monstrosities", by Dr. L. L. Hoskins; "A Case of Cerebral Embolus following Inguinal Herniotomy", by Drs. J. V. Seids and D. C. Bell; "Observations on Malignant Nephro-Sclerosis", (by invitation) by Dr. R. Dominguez; "Pneumoperitoneum Incident to Rupture of Peptic Ulcer without Peritonitis" (Report of two cases with recovery) by Dr. W. C. Stoner; "Homonymous Hemianopsia" (Report of two cases) by Dr. N. W. Jacoby.

December 9—Pediatric Section. Program: "Hepatic Rickets", by Dr. Henry J. Gerstenberger; "Problems of Bone Metabolism", by Dr. Thomas B. Cooley, Medical Director, Children's Hospital of Michigan.

December 11—Experimental Medicine Section. Program: "Actions of Three Vanillin Derivatives Related to Tyramine", (by invitation) W. E. Hambourger, Ph.D.; "Comparative Sedative Effects of Opium Alkaloids", (by invitation) O. W. Barlow, Ph.D., in collaboration with Dr. M. F.

Stormont; "A Physical Method of Determining Calcium Concentration", (by invitation) Dr. W. F. von Oettingen, and R. E. Pickett, A. B.; "Experimental Treatment of Allergic Dyspneas", by Dr. A. J. Beams and (by invitation) O. W. Barlow, Ph.D.; "Synopsis of Clinical Mercury Excretion", by Drs. Torald Sollmann and H. N. Cole, and (by invitation) N. E. Schreiber, M. A.; Cinema: "The Effects of Drugs on the Gastric Movements."

December 16—Industrial Medicine and Orthopedic Section. Program: "Traumatic Neuroses Among Industrial Patients", by Dr. Joseph Fetterman; discussion opened by Dr. A. D. Finlayson; "Roentgenological Aspects of Injuries to the Spine", (illustrated) by Dr. M. A. Thomas; discussion opened by Drs. T. A. Willis and H. A. Mahrer.

December 18—Annual Meeting. Report of the Secretary-Treasurer, Dr. Clarence H. Heyman; Annual Presidential Address, Dr. S. C. Lind; "The Doctor's Practice in the Future", by Dr. Henry F. Vaughan, Commissioner of Health of Detroit.—Bulletin.

Ashtabula County Medical Society held its regular monthly meeting at the Broadway Inn, Geneva, on Thursday, December 10. Dr. Richard Dexter, of Cleveland, presented a very interesting and instructive paper on "Abscess of the Lung". Dr. Norvin C. Kiefer, of Geneva, was elected to membership in the society. Officers for 1931 were re-elected to serve in 1932, as follows: President, Dr. P. J. Collander, Ashtabula; vice president, Dr. R. B. Wynkoop, Ashtabula; secretary-treasurer and correspondent for *The Journal*, Dr. E. H. Merrell, Geneva; legislative committeeman, Dr. Wynkoop; delegate to state meeting, Dr. Wynkoop; alternate Dr. A. J. Pardee, Ashtabula. —E. H. Merrell, Secretary.

Lake County Medical Society held a combined dinner-meeting with the Lake County Bar Association, on Friday evening, November 27, at the Parmly Hotel, Painesville, with Dr. W. R. Carle, of Perry, president of the Medical Society, presiding. "The Doctor in Court" was the subject of a splendid address given by Dr. Walter G. Stern, of Cleveland. Martin A. Tuttle, president of the Bar Association, and E. F. Blakely responded on behalf of the association with short talks.—News Clipping.

Lorain County Medical Society held its annual meeting at the Elyria Memorial Hospital, Tuesday, December 8, commencing with a five o'clock dinner. "Anatomy of the Female Pelvis and Perineum", was the subject of a scientific medical motion picture with sound, shown through the courtesy of the Petrolagar laboratories.—Bulletin.

Sixth District

Mahoning County Medical Society held its regular meeting on Tuesday evening, November 24, at the Youngstown Club in Youngstown. "Practical Application of Some Principles of Nutrition", was the subject of an address by Dr. A. Graeme Mitchell, Cincinnati, Professor of Pediatrics, University of Cincinnati College of Medicine. The meeting of Tuesday, December 15, in the Stambaugh Auditorium, Youngstown, was addressed by Dr. Chevalier Jackson, of Philadelphia, on the subject of "Prevention of a Certain Class of Accidents to Children". His lecture was accompanied by motion picture demonstration, and a display of articles taken from the throat and lungs of patients.—News Clipping.

Portage County Medical Society held its annual business meeting at the home of Dr. W. J. Thomas, Ravenna, on Thursday evening, December 3. Annual reports were presented at the business session. Election of officers for 1932 resulted as follows: President, Dr. Paul H. Zinkhan, Ravenna; vice president, Dr. E. M. Kauffman, Kent; secretary-treasurer and correspondent for *The Journal*, Dr. Emily J. Widdecombe, Kent, (re-elected); legislative committeeman, Dr. George J. Waggoner, Ravenna; medical defense committeeman, Dr. W. B. Andrews, Kent. Following the business session, Dr. Krape presented a case report on "Diphtheria", and Dr. Woolf, a case report. Dr. W. B. Andrews presented a paper on "Collections and Financial Management in Private Practice". All papers were freely discussed. Records show an average attendance at each meeting for 1931 to be fifty per cent of the total membership.—Emily J. Widdecombe, Secretary.

Stark County Medical Society held its regular meeting on Tuesday evening, December 8, at the Canton Woman's Club. The following program was presented: "Laval Therapy in the Treatment of Osteomyelitis and Acute Surgical Infections", (illustrated with moving pictures) by Dr. G. C. Weil, Mercy Hospital, Pittsburgh, Pennsylvania; "Surgery of the Sympathetic Nervous System", by Dr. Harold G. Kuehner, Mercy Hosiptal, Pittsburgh; "The Treatment of Intra-cranial Injuries by Hypertonic Solutions", by Dr. John Henry, Mercy Hospital, Pittsburgh.—Bulletin.

Summit County Medical Society held its nintieth annual meeting on Tuesday evening, December 1 at the Akron City Club, with an attendance of 256—the largest medical meeting ever held in Summit County. Dr. J. H. Selby was elected president-elect, and Dr. A. S. McCormick was re-elected as secretary-treasurer. Dr. E. R. Stumpf, president-elect, becomes president of the Society on January 5, 1932. Following the election, the Doctor's Orchestra gave a wonderful program in its 33d concert, and was hailed by the large audience as a remarkably fine organization. Following the concert, motion and talking pictures were exhibited through the courtesy of the Petrolagar Company. The picture, "Vaginal Hysterectomy and Uterine Prolapse" was made

by Dr. H. O. Jones, professor of Gynecology, Northwestern University, Chicago.—A. S. McCormick, Secretary.

Wayne County Medical Society held its regular meeting Tuesday, December 8, in Hygeia Hall, College Campus, Wooster, with a large attendance. Dr. A. T. Bunts, Cleveland Clinic, was the speaker. His subject, "Diagnosis of Spinal Cord Tumors" was very able and scholarly, and thoroughly illustrated by lantern slides; the salient features were so minutely presented that a diagnosis seems to be much more easily made than heretofore thought possible. Dr. Bunts has the sincere thanks of our Society. Being the annual meeting, the Society elected the following officers: President, Dr. E. H. McKinney, Doylestown; vice president, Dr. W. A. Morton, Wooster; secretary-treasurer, Dr. R. C. Paul, Wooster, (re-elected); censor, Dr. Jean Douglas, Wooster; delegate to state meeting, Dr. Paul; alternate, Dr. J. B. Patterson. The following are chairmen of committees: Membership, Dr. L. A. Adair, Wooster; program, Dr. H. A. Wildman, Wooster; medical defense, Dr. F. E. Snyder Rittman; legislative, Dr. W. B. Turner, Wooster.—R. C. Paul, Secretary.

Seventh District

Belmont County Medical Society held a joint meeting with the Belmont County Dental club on Thursday evening, November 12, at Kilkenny Inn, near St. Clairsville. Following the dinner, Charles Elliott, D.D.S., of Pittsburgh, spoke on "Focal Infections". The subject was further discussed by Dr. J. C. Archer of Bellaire and Dr. R. H. Wilson of Martins Ferry.—News Clipping.

Columbiana County Medical Society held a well-attended meeting on Tuesday, November 10 in Salem. Dr. Clayton C. Perry, of Cleveland, gave a very interesting talk on "Diagnosis and Treatment of Ano-Rectal Diseases". His address was instructive, and the members discussed it in the form of asking questions. The December meeting of the Society, held at the Travelers Hotel, East Liverpool, on Tuesday afternoon, December 8, was addressed by Drs. Theodore L. Bliss, Sewickly, Pennsylvania, and Dr. Norman C. Ochsenhirt, Pittsburgh. Dr. Bliss spoke on "Medical Aspects of Jaundice", and Dr. Ochsenhirt discussed "Surgical Aspects of Jaundice". Both speakers were formerly of the Mayo Clinic.—T. T. Church, Secretary.

Eighth District

Fairfield County Medical Society met Tuesday, November 10, at the Florentine Restaurant, Lancaster, for its annual meeting. Officers elected for 1932 are: President, Dr. W. B. Taylor, Pickerington; vice president, Dr. L. E. Stenger, Lancaster; secretary-treasurer and correspondent for *The Journal*, Dr. Carl W. Brown, Lancaster (re-elected); legislative committeeman, Dr. C. G. Axline, Lancaster; medical defense committeeman, Dr. B. H. Biddle, Sugargrove; delegate to state meeting, Dr. R. H. Smith, Lancaster; alternate, Dr. C. H. Hamilton, Lancaster. Luncheon was enjoyed in connection with the meeting, and a number of interesting case reports were presented. The luncheon meeting of the Society, held Tuesday, November 24, at the Florentine, was addressed by Dr. G. Wayne Brehm, Columbus.—News Clipping.

Guernsey County Medical Society was host to visiting physicians from Belmont, Coshocton, Noble and Muskingum County Medical societies, at a dinner held at the Romance Restaurant, Cambridge, on Thursday evening, November 19. Seventy members attended the meeting, which was addressed by Dr. George W. Crile, of Cleveland.—News Clipping.

Muskingum County Academy of Medicine held its annual meeting on Wednesday evening, December 2, at the Zane Hotel, with an attendance of 33 members. Following the dinner, Dr. H. M. Brundage, Columbus, gave a talk on "Analysis of Heart Murmurs", with demonstration by means of Victrola records. The annual election of officers resulted as follows: President, Dr. A. H. Gorrell, Zanesville; vice president, Dr. H. A. Martin, Gratiot; secretary-treasurer and correspondent for *The Journal*, Dr. Beatrice T. Hagen, (re-elected); legislative committee, Dr. Hagen, chairman; Drs. W. D. Coffman, and C. J. Roach; medical defense committee, Dr. C. M. Rambo, chairman; Drs. J. C. Crossland and O. I. Dusthimer; delegate to state meeting, Dr. M. A. Loebell; alternate, Dr. G. B. Trout.—Beatrice T. Hagen, Secretary.

Ninth District

Seioto County—The annual meeting of the Hempstead Academy of Medicine was held on Monday afternoon, December 14, followed by the annual banquet at 6:30 P. M., at the Washington Hotel, Portsmouth, with Dr. J. N. Ellison, as toastmaster. "Looking Forward" was the subject of the message of the president-elect for 1932. "Accomplishments of 1931" was the subject of the address of the retiring president, Dr. George D. Martin, which was followed by an address by Dr. H. M. Platter, Columbus, president-elect of the Ohio State Medical Association, and "Hempstead Academy Banquet", by Fernando C. Searl, of Portsmouth. Dr. W. S. Coy, Bristol, Tennessee, spoke on "Some Misconceptions of Focal Infections", and Dr. W. N. Taylor, Columbus, spoke on "Urological Suggestions and Procedures of Value to Practitioners". Neighboring county medical societies were invited to attend the banquet.

The following officers were elected for 1932: President, Dr. Clyde M. Fitch; vice-president, Dr. Wm. D. Micklethwaite; secretary-treasurer and correspondent for *The Journal*, Dr. Wm. E. Scaggs; legislative committeeman, Dr. A. L. Test;

medical defense committeeman, Dr. Joseph S. Rardin; delegate to state meeting, Dr. Gilbert Micklethwaite; alternate, Dr. W. A. Quinn.—Bulletin.

Tenth District

COLUMBUS ACADEMY OF MEDICINE

(James A. Beer, M.D., Secretary)

November 16—Regular meeting at the Columbus Public Library. Program: "Medical History", by Dr. E. F. McCampbell; "Tachycardia", by Drs. R. A. Ramsey, J. W. Wilce and R. W. Kissane.

November 22—Program: "Treatment of Post-Partum Hemorrhage", by Dr. J. F. Baldwin; "Esophageal Diseases", by Dr. J. D. Dunham; "Diagnostic Injection with Later Resection of Stellate Ganglion for Causalgia", by Drs. R. B. Drury and H. H. Schwarzell; "A Case of Mediastinal Tumor", by Dr. E. F. McCampbell; "A Spindle-Cell Sarcoma Growing from the Parietal Peritoneum", by Dr. I. B. Harris; "Diagnosis of Acute Mastoiditis", by Dr. Francis Thomas; "A Report of Two Unusual Obstetrical Cases", by Dr. S. J. Goodman; "A Wilms' Tumor", by Dr. Frank Harrah.

November 30—Program. Birth Control as Viewed from a Medical Standpoint. The status of obstetrics in general practice was also discussed by Drs. S. J. Goodman, R. B. Taylor, C. C. Ross, Wayne Brehm, and J. F. Baldwin. Dr. C. M. Valentine, chairman of the section, presided.—Bulletins.

December 14—Approximately 250 members of the Academy and guests attended the annual banquet given the evening of December 14 at the Columbus Athletic Club.

Following the dinner, Dr. Joseph Price, retiring president of the Academy and presiding as toastmaster, called upon Dr. C. O. Probst to pay tribute to the memory of 17 members of the Academy who had died during the past year. Dr. Probst, speaking on the subject, "What a Good Doctor Means to His Community", analyzed the characteristics which make a physician a leader in his community. At the conclusion of his remarks, those present stood while the names of the members of the Academy who died during the year were read, namely: Drs. E. E. Adel, J. J. Beekman, M. W. Bland, C. F. Clark, W. C. Heintz, Austin Hutt, Alice M. Johnston, Lewis Kahn, Josiah Medbery, G. W. Miller, J. K. McCready, L. McKitrick, E. W. Schueller, H. H. Snively, G. L. Williams, Frank Winders and T. K. Wissinger.

Dr. Irving S. Cutter, dean of the College of Medicine, Northwestern University, was the guest speaker of the evening. Dr. Cutter presented a highly entertaining and historical address on "Puerperal Fever", illustrated with lantern slides, in which he reviewed the work of White, Wallace, Gordon and other European medical authorities, and Oliver Wendell Holmes of the American medical profession, with puerperal fever, pointing out that the principles laid down by these men still are fundamental in the prevention of septicemia following childbirth.

As an additional feature of the program, Dr. E. E. Campbell presented a patient who had recently contracted tularemia in dressing a rabbit, and was assisted in the clinical analysis of the case by Dr. Walter M. Simpson, Dayton.

NEW COUNTY SOCIETY OFFICERS

In addition to results of annual elections reported in the foregoing County Society news, the following county societies have elected officers for 1932:

Champaign County—President, Dr. E. D. Buhrer, Urbana; president-elect, Dr. N. M. Rhodes, Urbana; secretary-treasurer and correspondent for *The Journal*, Dr. L. A. Woodburn, Urbana, (re-elected); legislative committeeman, Dr. E. R. Earle, Urbana; medical defense committeeman, Dr. Mark Houston, Urbana; delegate to state meeting, Dr. E. W. Ludlow, Urbana; alternate, Dr. J. W. Norman, St. Paris.

Clermont County—President, Dr. T. A. Speidel, Felicity; secretary-treasurer, Dr. Allan B. Rapp, Owensville (re-elected); correspondent for *The Journal*, Dr. W. J. Hughes, Moscow; legislative committeeman, Dr. Thomas Longworth, Felicity; medical defense committeeman, Dr. F. H. Lever, Loveland; delegate to state meeting, Dr. Speidel; alternate, Dr. Rapp.

Crawford County—President, Dr. K. H. Barth, New Washington, vice-president, Dr. E. C. Brandt, Crestline; secretary-treasurer, Dr. A. E. Loyer, New Washington, (all re-elected); correspondent for *The Journal*, Dr. C. A. Lingenfelter, Bucyrus; legislative committeeman, Dr. W. G. Carlisle, Bucyrus; medical defense committeeman, Dr. W. L. Yeomans, Bucyrus; delegate to state meeting, Dr. R. J. Caton, and alternate, Dr. W. G. Carlisle, Bucyrus.

Delaware County—President, Dr. A. R. Callander; vice president, Dr. G. D. Lowry; secretary-treasurer and correspondent for *The Journal*, Dr. E. V. Arnold; legislative committeeman, Dr. M. S. Cherington; medical defense committeeman, Dr. J. K. James; delegate to state meeting, Dr. A. R. Callander; alternate, Dr. G. D. Lowry, all of Delaware.

Fulton County—President, Dr. Park S. Bishop, Delta; vice-president, Dr. G. R. Salsberry, Lyons; secretary-treasurer, Dr. George McGuffin, Pettisville; correspondent for *The Journal*, Dr. Wm. H. Maddox, Wauseon; legislative and medical defense committeeman, Dr. C. L. Hutchins, Delta; delegate to state meeting, Dr. Harold Heffron, Metamora; alternate, Dr. Floyd Hartman, Wauseon.

Geauga County—President, Dr. W. C. Cory, Chardon; vice-president, Dr. H. E. Shafer, Middlefield; secretary-treasurer and correspondent for *The Journal*, Dr. Isa Teed-Cramton, Burton; legislative committeeman, Dr. W. C. Cory; medical defense committeeman, and delegate to state meeting, Dr. C. F. Gilmore, Chesterland; alternate, Dr. Cory, (all re-elected).

Greene County—President, Dr. R. H. Grube, Xenia; vice-president, Dr. L. L. Taylor, Yellow Springs; secretary-treasurer and correspondent for *The Journal*, Dr. Hugh Schick, Xenia; delegate to state meeting, Dr. M. I. Marsh, Cedarville; alternate, Dr. C. E. Ream, Bowersville.

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PROMPT AND FULL REPORT

Hamilton County (Cincinnati Academy of Medicine)—President, Dr. Wm. M. Doughty; vice-president, Dr. Parke G. Smith; secretary and correspondent for *The Journal*, Dr. H. H. Shook; treasurer, Dr. E. O. Swartz; legislative committeeman, Dr. Robert B. Cofield; delegates to state meeting, Drs. J. Victor Greenebaum, Otto Seibert, Louis Feid, Jr., Charles E. Kiely, E. O. Smith and Henry B. Freiberg; alternates, Drs. R. L. Crudgington, Albert Brown, E. O. Swartz, Samuel Zielonka, Eslie Asbury, Symmes Oliver.

Huron County—President, Dr. John A. Sipher, Norwalk, (re-elected); vice-president, Dr. R. L. Morse, Norwalk; secretary-treasurer, Dr. B. C. Pilkey, Norwalk, (re-elected); legislative committeeman, Dr. W. C. Martin, Monroeville; delegate to state meeting, Dr. Sipher; alternate, Dr. Pilkey.

Jackson County—President, Dr. J. S. Hunter, Jackson; secretary-treasurer and correspondent for *The Journal*, Dr. J. J. McClung, Jackson.

Logan County—President, Dr. A. J. McCracken, Bellefontaine; vice-president, Dr. J. L. Maurer, West Liberty; secretary-treasurer and correspondent for *The Journal*, Dr. W. H. Carey, Bellefontaine.

Medina County—President, Dr. Harry Street, Litchfield; vice-president, Dr. E. C. Bell, Lodi; secretary-treasurer and correspondent for *The Journal*, Dr. J. K. Durling, Wadsworth, (re-elected); legislative committeeman, Dr. E. L. Crum, Lodi; delegate to state meeting, Dr. Crum, alternate, Dr. H. P. H. Robinson, Medina.

Montgomery County—President, Dr. F. K. Kislig; first vice-president, Dr. D. D. Borden; second vice-president, Dr. C. C. Payne; executive secretary, Miss Mildred E. Jeffrey; correspondent for *The Journal*, Dr. H. V. Dutrow; legislative and medical defense committeeman, Dr. Webster Smith (re-elected); delegates to state meeting, Drs. A. W. Carley, C. C. McLean and A. O. Peters; alternates, Drs. H. H. Hatcher, W. B. Bryant and F. K. Kislig, all of Dayton.

Morrow County—President, Dr. W. D. Moccabee, Cardington; vice-president, Dr. C. S. Jackson, Mt. Gilead; secretary, Dr. Todd Caris, Mt. Gilead (re-elected); treasurer and legislative committeeman, Dr. R. L. Pierce, Mt. Gilead (re-elected); medical defense committeeman, F. E. Thompson, Marengo; delegate to state meeting, Dr. F. M. Hartsook, Cardington; alternate, Dr. Pierce.

Perry County—President, Dr. Joseph Clouse, Somerset; vice-president, Dr. James Miller, Corning; secretary-treasurer and correspondent for *The Journal*, Dr. F. J. Crosbie, New Lexington (re-elected); legislative committeeman, Dr. R. W. Miller, Hemlock; medical defense committeeman, Dr. James Miller, Corning; delegate to state meeting, Dr. J. G. McDougal, New Lexington; alternate, Dr. W. D. Porterfield, Junction City.

Pike County—President, Dr. Paul Jones, Stockdale (re-elected); vice-president, Dr. O. R. Eylar, Waverly; secretary-treasurer, Dr. L. E. Wills, Waverly (re-elected); correspondent for *The Journal*, Dr. I. P. Seiler, Piketon; legislative committeeman, Dr. O. R. Eylar; medical defense committeeman, Dr. I. P. Seiler; delegate to state meeting, Dr. Eylar; alternate, Dr. Wills.

Preble County—President, Dr. J. I. Nisbet, Eaton (re-elected); vice-president, Dr. C. J. Brian, Eaton; secretary-treasurer, Dr. C. E. Newbold, Eaton; legislative committeeman, Dr. J. C. Ryder, Eaton; medical defense committee, Drs. J. B. Lucas, C. J. Brian and C. M. Treffinger; dele-

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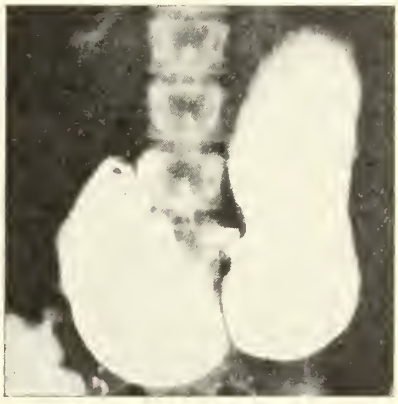
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gate to state meeting, Dr. Treffinger; alternate, Dr. Lucas.

Seneca County—President, Dr. E. H. Porter, Tiffin; vice-president, Dr. V. L. Magers, Tiffin; secretary-treasurer, Dr. R. E. Hershberger; legislative committeeman, Dr. M. W. Uberroth, Tiffin; medical defense committeeman, Dr. Paul Leahy, Tiffin; delegate to state meeting, Dr. R. C. Chamberlain, Tiffin; alternate, Dr. E. L. Overholt, Fostoria.

Tuscarawas County—President, Dr. C. J. Miller, New Philadelphia; vice-president, Dr. R. J. Foster, New Philadelphia; secretary-treasurer, Dr. G. L. Sackett, New Philadelphia; legislative committeeman, Dr. J. A. McCollam, Uhrichsville (re-elected); medical defense committeeman, Dr. H. A. Coleman, New Philadelphia; delegate to state meeting, Dr. J. W. Calhoon, Uhrichsville; alternate, Dr. W. H. Curtiss, Dennison.

Union County—President, Dr. E. J. Marsh, Broadway; vice-president, Dr. R. H. Martin, Magnetic Springs; secretary-treasurer, Dr. Angus MacIvor, Marysville (re-elected); correspondent for *The Journal*, Dr. J. D. Boylan, Milford Center; legislative committeeman, Dr. F. C. Callaway, Marysville; medical defense committeeman, Dr. C. D. Mills, Marysville; delegate to state meeting, Dr. J. D. Boylan; alternate, Dr. Angus MacIvor.

Warren County—President, Dr. J. E. Witham, Waynesville, (re-elected); vice-president, Dr. P. W. Tetrick, Mason; secretary, Dr. James H. Arnold, Lebanon (re-elected); treasurer, Dr. Mary L. Cook, Waynesville (re-elected); legislative committeeman, Dr. S. S. Stahl, Franklin; medical defense committeeman, Dr. N. A. Hamilton, Franklin; delegate to state meeting, Dr. B. H. Blair, Lebanon; alternate, Dr. N. A. Hamilton.

Washington County—President, Dr. S. E. Edwards, Marietta; vice-president, Dr. Gordon James; secretary-treasurer, Dr. E. W. Hill, Jr., Marietta (re-elected); medical defense committeeman, Dr. S. A. Cunningham, Marietta.

PUBLIC HEALTH NOTES

Although 1569 persons were killed in automobile accidents in Ohio during the first 10 months of 1931, according to death records filed in the State Department of Health, Division of Vital Statistics, a study of the monthly reports indicates that fewer persons will be listed among the killed in automobile accidents in 1931 than in 1930.

In the first 10 months of 1931, only January, March and July show a greater number of deaths than during the same period in 1930. There were 179 fewer deaths in this period than were reported for the first 10 months of 1930, when 1748 were listed.

The greatest reduction is noted in deaths from automobile accidents at grade-crossings in connection with railroad trains, as there were 233 in 1930 and only 131 this year. However, this reduction has been brought about since June. The average number of monthly deaths from this cause is 23; in July there were only three reported, in August 10, and only four in September. But the reverse of this condition is found in the number of deaths due to automobile accidents in connection with streetcars and interurbans, as 24 of the 35 deaths for 1931 have been reported since June. For this period in 1930, 50 deaths were reported, a decrease of 15.

In a study of the place of the accident as indicated on the original certificate, it was found that the decrease in accidents in the cities is no greater than in rural districts. In 1930 there were 18 records that did not indicate the place of the accident as compared with 47 in 1931. In 1931 there were 640 accidents in rural districts, as compared with 661 in 1930, and 716 in the cities in 1931, as compared with 796 in 1930.

A comparison of the connection the person had with the automobile when killed indicates very little change in 1931. In 1931, 556 certificates did not indicate whether the person was a pedestrian, driver or passenger, as compared with 532 in 1930. In 1931, 591 pedestrians were killed, compared with 659 in 1930; 119 drivers in 1931 and 99 in 1930, and only 37 passengers in 1931, against 75 for the period in 1930.

In a study of how the accidents occurred, it is found that fewer automobile collisions occurred, in both rural and city districts in 1931. However, more automobiles ran off the road and upset

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during the first 10 months of 1931 than 1930, and fewer trucks were involved in accidents in 1931 than in 1930, but more persons were hit by passing automobiles in 1931.

Following is a comparison of this information: Automobile ran off the highway and upset, 83 in 1931, 72 in 1930; automobile collisions in the rural districts, 64 in 1931, 90 in 1930; automobile collisions in the city, 42 in 1931, 43 in 1930; persons killed by gas in a closed car, 18 in 1931, 22 in 1930; number of accidents in which trucks were involved, 33 in 1931, 60 in 1930; number of accidents in which passenger buses were involved, 3 in 1931, 11 in 1930; the number of accidents in which school buses were involved, 3 in 1931, 18 in 1930; 57 accidents occurred in 1931 when the automobile ran into fixed objects and only 46 in 1930; 555 accidents were caused by the person being hit by a passing machine in 1931, as compared with 440 in 1930; all other and unknown means caused 545 deaths in 1931, against 672 in 1930, which indicates that physicians and coroners are giving more detailed information in automobile accidents.

During 1930 there were 2063 deaths due to automobile accidents not in connection with heavier vehicles. The certificates indicated that 40 of them were due to absorption of poisonous gas from the machine; 10 with accidental burning in connection with the automobile; two men working on a machine that fell on them; four drowned when the machine went over the bank into the water; 25 fell from moving automobiles and 274 were crushed under machines during collisions.

—A recent examination of 2290 school children at Dayton, under the auspices of Dr. A. O. Peters, city health commissioner, disclosed 53 having heart defects; 634 with defective tonsils and 508 with defective teeth. In all, 1922 children were found to have some physical defect.

—Dr. J. J. Sutter has been re-appointed health commissioner of Allen County.

—Dr. G. W. Fishbaugh, Minford, has been appointed health commissioner of Scioto County, succeeding Dr. R. W. DeCrow who has held that position for the past 12 years.

—Sewerage and sewage disposal bond issues were submitted to the voters of 12 Ohio municipalities at the recent general eletcion but only one of the twelve (Shelby) was able to muster the necessary 60 per cent majority to authorize the bond issue, according to a check up made by the State Department of Health.

The following summary of the present situation was published in a recent issue of the *Ohio Health News*, official publication of the State Department:

Five of the municipalities that rejected the bond issue proposals were under state order to construct the necessary sewage disposal facilities for correction of stream pollution nuisances (Bedford, Bowling Green, New Bremen, Van Wert, Washington C. H.) The foregoing list of municipalities that voted upon bond issue questions does not represent all the Ohio communities that are still under state order to provide the needed sewage disposal facilities in order to correct outstanding stream pollution nuisances.

In view of the outcome of the municipal elections it would appear that some other means of financing sewage disposal improvements must be followed. There is a perfectly practicable way of accomplishing such improvements whete they are badly needed. In 1923 the General Assembly enacted what is known as a "Sewer Rental Law" which was an enabling act permitting Ohio municipalities to place the sewerage system on almost the same basis as the water system, namely, as a utility. In other words municipalities are permitted to collect charges for sewerage and sewage disposal service on a schedule of rates which the municipality may determine to its own satisfaction; the revenue thus derived may be used for operation and maintenance of the sewerage and sewage disposal devices, and any surplus may be applied to the sinking fund charges on bonds, or for direct expenditure toward sewage disposal improvements.

The first municipality to take advantage of this way of financing was the village of Oxford, which started to charge for sewer service in 1925 with the result that in 1929 it was enabled to build a new sewage disposal plant, funds for which were obtained largely from the earnings of the sewer department. The largest municipality that has financed in this manner is the city of Dayton. A new plant, recently placed in service in that city is being paid for out o fthe sewer rental fund. Each Dayton householder that uses the sewer system pays approximately $4.00 per annum. It is possible to arrange the schedule of charges so that each user of the system pays in direct proportion to the use he makes of the

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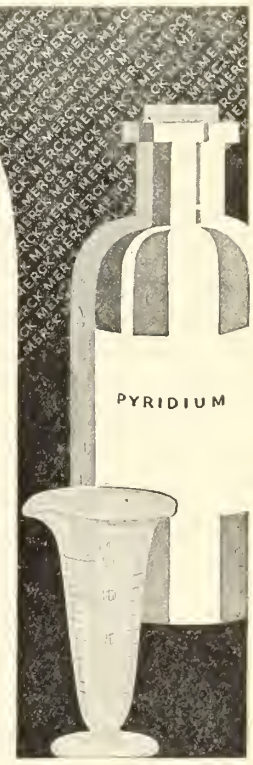


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system, namely, in proportion to the volume and strength of the sewage (especially in the case of a manufacturing establishment). This is essentially the same manner in which charges for water service are made, as such charges vary in proportion to the volume of water taken. About 20 Ohio municipalities are paying for this sewage disposal service under provisions of the sewer rental law. All it requires is an ordinance of council establishing standard rates of service charges.

Ohio municipalities really desiring to clean up stream pollution nuisances and prevent costly lawsuits for damages can proceed, if they choose to, by adopting this method of financing, as above described, without placing undue burdens on taxpayers but putting the cost where it really belongs—on users of the system.

Following are the results of the votes on bond issues for water supply, sewerage and sewage disposal projects:

WATER IMPROVEMENT PROJECTS

Approved

Dresden (improvements)	$ 4,500
Roseville (new water works)	40,000
Weft Lafayette (improvements)	7,500

Defeated

Belpre	Franchise for water works system
Canton (extensions and improvements)	$145,000
Fayette (new water works)	46,000
Gahanna (new water works)	12,000
Mechanicsburg	Purchase of Private water works
Scioto County-Valley Township (new water works)	$ 20,000
Wellsville (filtration plant)	135,000
Woodsfield (new water works)	50,000

SEWERAGE AND SEWAGE DISPOSAL PROJECTS

Approved

Shelby (sewage treatment plant)	$150,000

Defeated

Bedford (sewers and sewage treatment plant)	$175,000
Bowling Green (sewers and sewage treatment plant)	280,000
Canton (sanitary sewers)	138,000
Canton (storm sewers)	283,000
Coldwater (sewers)	116,000
East Palestine (sewage treatment plant)	26,000
Franklin (storm sewers)	55,000
New Bremen (sewage treatment plant)	40,000
Sebring (sewage treatment plant)	55,000
Van Wert (sewers and sewage treatment plant)	500,000
Washington C. H. (sanitary sewers)	125,000
Washington C. H. (sewage treatment plant)	25,000
Willard (sanitary sewers)	60,000

—The United States Public Health Service has recently completed a statistical study of the age and sex variation in cases of influenza and pneumona. This study summarizes the age and sex variation in influenza and pneumonia morbidity and mortality during the 1928-29 and the 1918-19 epidemics. It is based on canvasses following each epidemic of families including nearly 150,000 persons in about 12 localities in the United States.

While there are some similarities in the 1928-29 and 1918-19 age curves, the differences are more striking than the similarities. The young adult peak in pneumonia incidence and in mortality in 1918-19 was absent in 1928-29.

Pneumonia incidence and the death rate were both much higher in 1918-19 than in 1928-29 but the percentages of pneumonia cases that were fatal were not greatly different in the two epidemics. There was a very large difference in the percentage of cases complicated by pneumonia in the two epidemics; but once pneumonia existed, the chance of fatal outcome was nearly the same in both years.

Statistical data of this kind give no clue as to the reason for the striking difference in age incidence in the two epidemics, and any attempt at explanation would be only conjecture.

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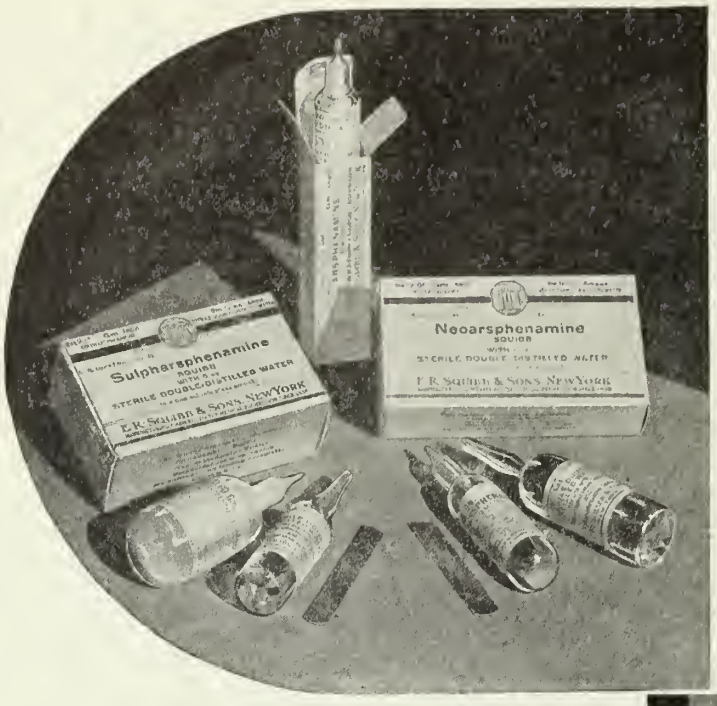
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Sandusky	C. L. Smith, Fremont	L. N. Bates, Fremont	Last Thursday, monthly.
Williams	A. Hathaway, Edon	B. C. Bly, Montpelier	3d Thursday, monthly.
Wood	O. S. Canright, Haskins	F. V. Boyle, Bowling Green	3d Thursday, monthly.
Fifth District	C. L. Cummer, Councilor	Chrm. Com. on Arrangements	Cleveland.
Ashtabula	P. J. Collander, Ashtabula	E. H. Merrell, Geneva	1st Tuesday, monthly.
Cuyahoga	H. G. Sloan, Cleveland	Clarence H. Heyman, Cleveland	3d Fri. March, May, Sept., Nov., Dec.
Erie	H. W. Lehrer, Sandusky	G. A. Stimson, Sandusky	Last Thursday, monthly.
Geauga	W. C. Cory, Chardon	Isa Teed-Cramton, Burton	Last Wednesday, Apr. to Dec
Huron	John A. Sipher, Norwalk	B. C. Pilkey, Norwalk	2d Thursday, monthly.
Lake	W. R. Carle, Perry	F. J. Dineen, Painesville	4th Tuesday, monthly.
Lorain	David Thomas, Lorain	W. E. Hart, Elyria	2d Tuesday, monthly.
Medina	Harry Street, Litchfield	J. K. Durling, Wadsworth	3d Thursday.
Trumbull	H. J. Meister, Warren	R. H. McCaughtry, Warren	3d Thursday, monthly, except June, July, August.

Societies	President	Secretary	
Sixth District	J. G. Blower, Akron	J. H. Seiler, Akron	2d Wed., Jan., April & Oct.
Ashland	W. F. Emery, Ashland	Paul E. Kellogg, Ashland	1st Friday, bi-monthly.
Holmes	L. E. Anderson, Mt. Hope	C. T. Bahler, Walnut Creek	1st Tuesday, quarterly, Jan., April, July, October.
Mahoning	A. E. Brant, Youngstown	W. M. Skipp, Youngstown	3d Tuesday, monthly.
Portage	Paul H. Zinkhan, Ravenna	E. J. Widdecombe, Kent	1st Thursday, monthly.
Richland	W. H. Buker, Bellville	P. A. Stoodt, Mansfield	3d Thursday, monthly.
Stark	H. M. Schuffell, Canton	F. S. VanDyke, Canton	2d Tuesday monthly except July and August.
Summit	E. R. Stumpf, Akron	A. S. McCormick, Akron	1st Tuesday, monthly.
Wayne	E. H. McKinney, Doylestown	R. C. Paul, Wooster	2d Tuesday, monthly.
Seventh District			
Belmont	W. M. Garrison, St. Clairsville	C. W. Kirkland, Bellaire	2d Wednesday, monthly at 1:45 p.m.
Carroll	(With Stark Co. Society)		
Columbiana	G. E. Byers, Salem	T. T. Church, Salem	2d Tuesday, monthly.
Coshocton	R. E. Hopkins, Coshocton	J. D. Lower, Coshocton	4th Thursday, April, June, Sept., December.
Harrison	A. C. Grove, Jewett	W. C. Wallace, Hopedale	3d Wednesday, monthly.
Jefferson	Victor Biddle, Steubenville	John Y. Bevan, Steubenville	Last Friday, monthly.
Monroe	G. W. Steward, Woodsfield	A. R. Burkhart, Woodsfield	2d Wednesday, monthly.
Tuscarawas	C. J. Miller, New Phila.	G. L. Sackett, New Phila.	2d Thursday, monthly.
Eighth District			
Athens	L. D. Nelson, The Plains	T. A. Copeland, Athens	1st Monday, monthly.
Fairfield	W. B. Taylor, Pickerington	C. W. Brown, Lancaster	2d Tuesday, monthly.
Guernsey	M. S. Lawrence, Quaker City	C. C. Headley, Cambridge	1st and 3rd Tuesday each month
Licking	C. J. Dillon, Newark	D. A. Skinner, Newark	Last Friday, monthly.
Morgan	D. G. Ralston, McConnelsville	C. E. Northrup, McConnelsville	3d Wednesday, monthly.
Muskingum	A. H. Gorrell, Zanesville	Beatrice T. Hagen, Zanesville	1st Wednesday, monthly.
Noble			
Perry	Joseph Clouse, Somerset	F. J. Crosbie, New Lexington	3d Monday, monthly.
Washington	S. E. Edwards, Marietta	E. W. Hill, Jr., Marietta	2d Wednesday, monthly.
Ninth District			
Gallia	O. A. Vornholt, Gallipolis	Milo Wilson, Gallipolis	1st Thursday, monthly.
Hocking	H. M. Boocks, Logan	M. H. Cherrington, Logan	Quarterly.
Jackson	J. S. Hunter, Jackson	J. J. McClung, Jackson	1st Tuesday, monthly.
Lawrence	F. R. Stewart, Ironton	Chas. H. Gallagher, Ironton	1st Thursday, monthly.
Meigs	P. A. Jividen, Rutland	Byron Bing, Pomeroy	1st Thursday, April, July and Oct
Pike	Paul Jones, Stockdale	L. E. Wills, Waverly	1st Monday, monthly.
Scioto	C. M. Fitch, Portsmouth	Wm. E. Scaggs, Portsmouth	2d Monday, monthly.
Vinton	O. S. Cox, McArthur	H. S. James, McArthur	3d Wednesday, monthly.
Tenth District			
Crawford	K. H. Barth, New Washington	A. E. Loyer, New Washington	1st Monday, monthly.
Delaware	A. R. Callander, Delaware	E. V. Arnold, Delaware	1st Tuesday, monthly.
Franklin	James H. Warren, Columbus	John H. Mitchell, Columbus	1st four Mondays.
Knox	S. O. Gantt, Centerburg	R. L. Eastman, Mt. Vernon	Last Thursday, monthly.
Madison	R. S. Postle, London	G. C. Scheetz, West Jefferson	4th Wednesday.
Morrow	W. D. Moccabee, Cardington	T. Caris, Mt. Gilead	1st Wednesday, monthly.
Pickaway	G. F. Kaler, New Holland	Lloyd Jonnes, Circleville	1st Friday, monthly.
Ross	Glen Nisley, Chillicothe	W. C. Breth, Chillicothe	1st Thursday, monthly.
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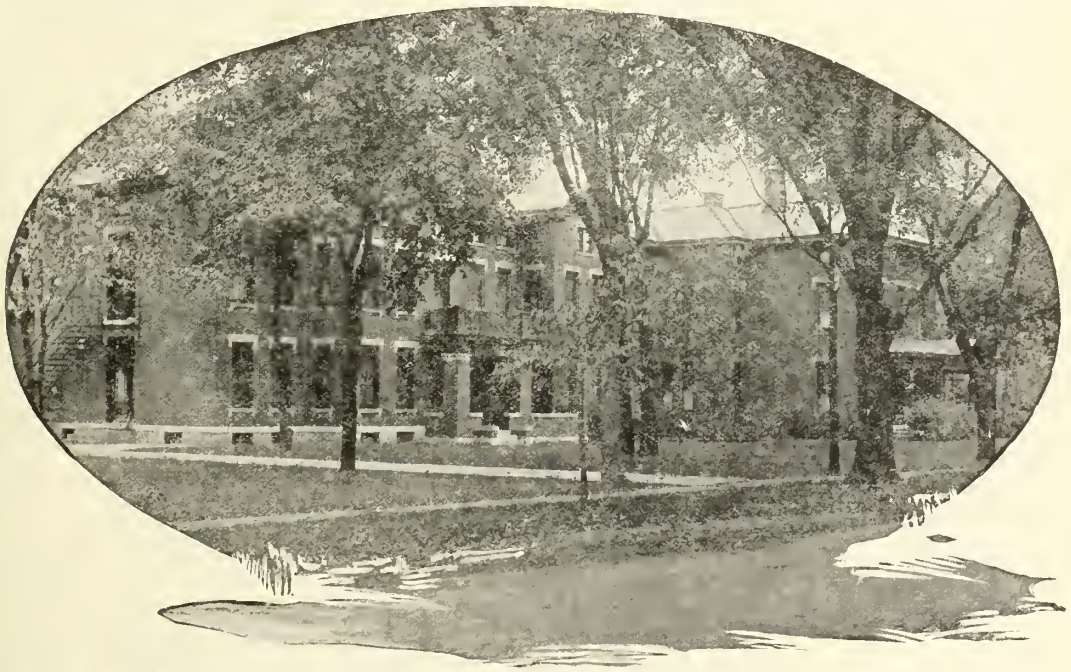
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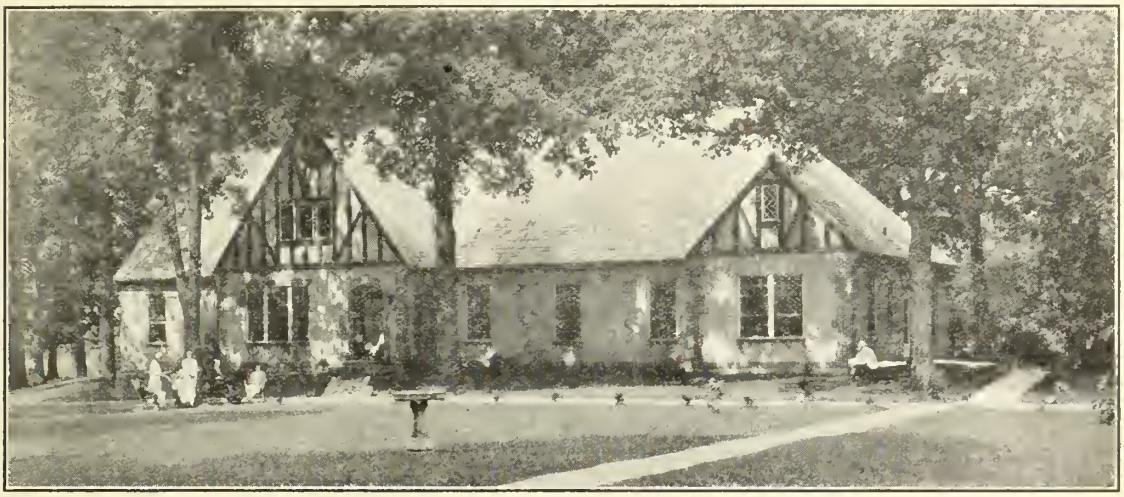
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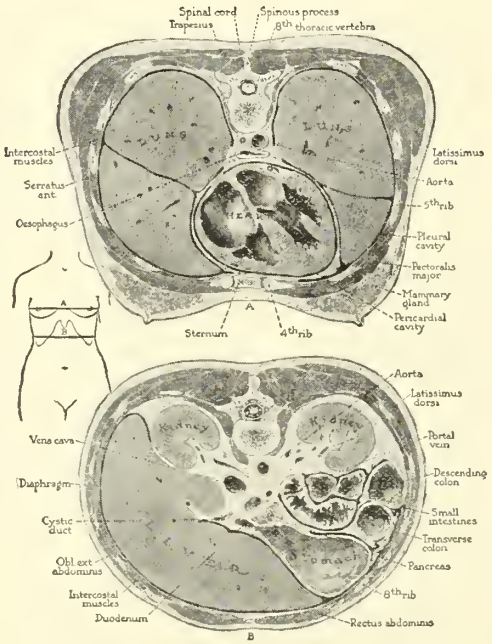
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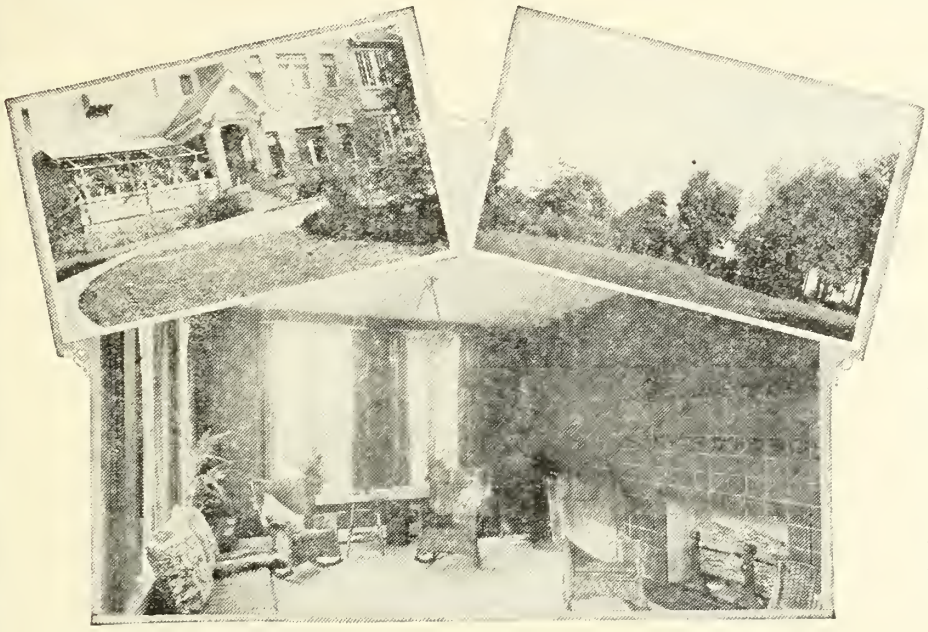
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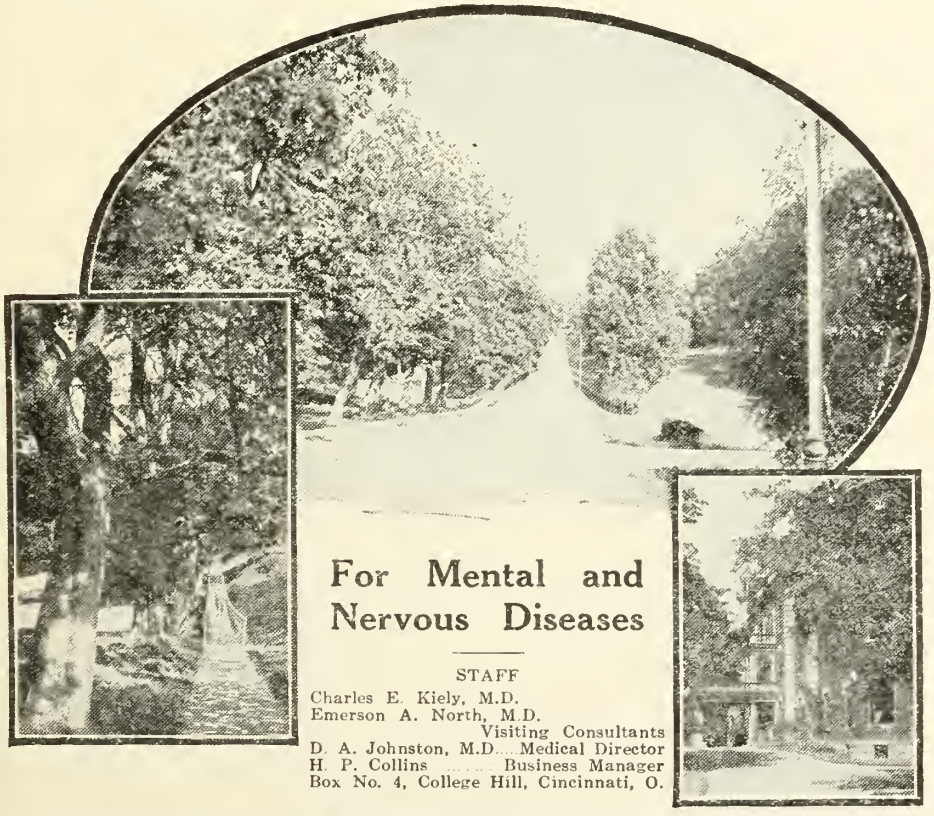
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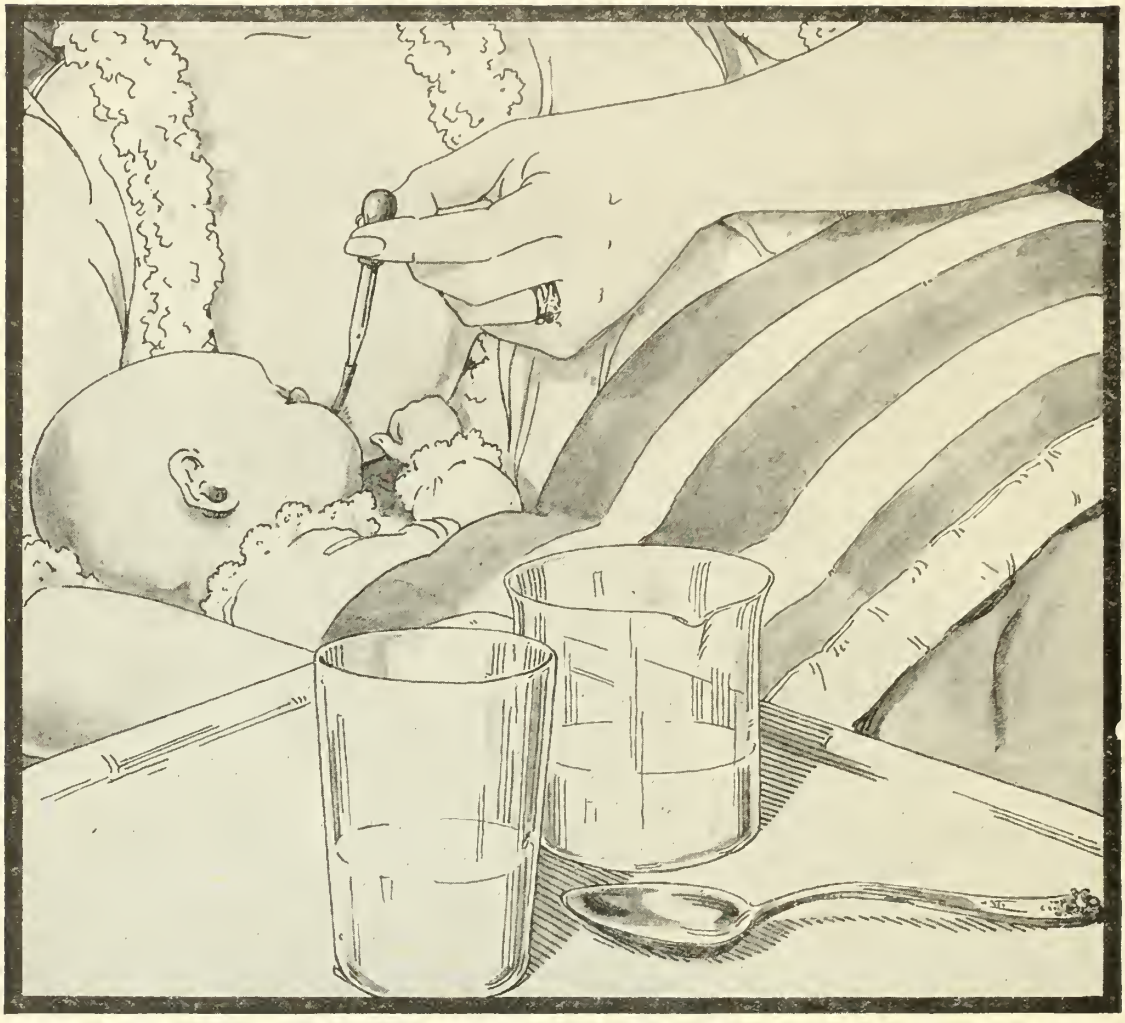
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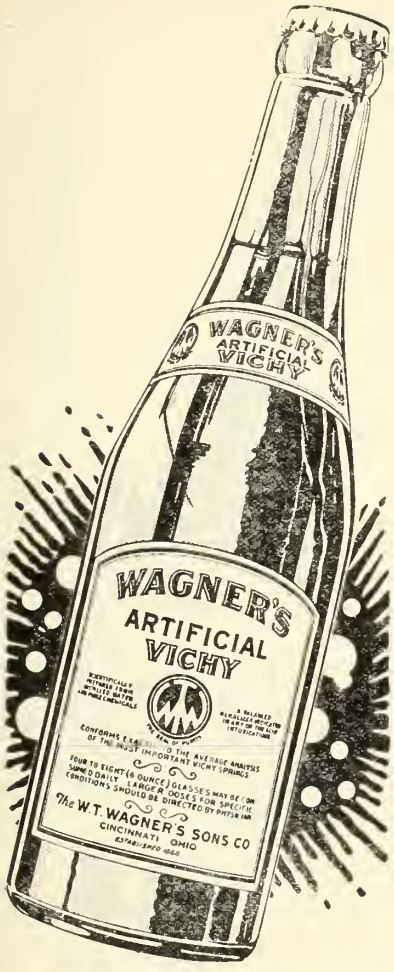


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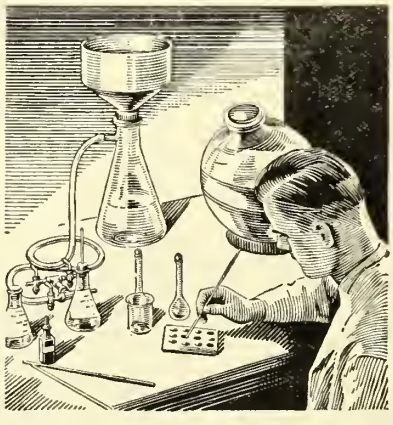
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PUBLIC HEALTH — SOCIAL WELFARE MEDICAL ECONOMICS and ORGANIZATION PROBLEMS

With Editorial Comment by D.K.M.

Developments of the past few years have demonstrated that organization is the chief bulwark of the medical profession against repeated and insidious efforts to socialize completely the practice of medicine, reduce the profession to the status of a trade, and destroy the beneficial relationship between patient and doctor.

Organization Is Imperative In These Times

One of the most timely discussions presented on the question, of what is expected of medical organization in these trying times, and how medical organization should proceed to meet the issues confronting the medical profession, was the address delivered by Dr. Albert H. Freiberg, Cincinnati, former president of the Ohio State Medical Association, at the last Annual Conference of Secretaries of Constituent State Medical Associations of the American Medical Association, held in Chicago.

In his customary logical and interesting manner, Dr. Freiberg reviewed social, economic and political developments which have had a deep effect on the practice of medicine and emphasized the necessity of the maintenance of strong and united medical organization, under capable and fearless leadership, and the development of constructive and practical programs of activity by all component units of organized medicine.

Concerning the responsibility of medical organization for developing group thought in the medical profession on the social-economic aspects of medical practice, Dr. Freiberg said:

"I believe that nothing can ever occur to make the scientific and technical functions of medical organizations less than primary in their importance to their membership. Nevertheless, the life of the world has become so vitally altered by the accomplishments of modern medicine itself and the activities of the physician so greatly modified by developments of social, economic and even of political character that medical organization must take cognizance of them. Consideration of these elements must be incorporated in the activities of medical societies, perforce."

Granting that medical organization must devote serious thought and study to these baffling problems, as it is doing with increasing vigor, what is the proper attitude that should be assumed by medical organization after it has thought through the issues under discussion?

Should medical organization be passive and permit others to attempt solution of these questions? Should it strike an attitude of passive resistance; one of half-hearted assistance? Or, should it cooperate and initiate aggressive and militant activity when advisable to do so?

Dr. Freiberg's views on these angles of medical organization's participation in social-economic-political questions are not only timely, but quite to the point. He said:

"* * * And where lies the solution for the wide divergence in thought concerning medical matters between physicians and those laymen of good intent and benevolent purpose who have raised their voices? It is surely not to be found in an attitude of indifference; neither will it come out of an attempt to cast doubt on their sincerity of purpose. It must rather be our object to convert our attitude into one perfectly definite and outspoken in respect of all of these matters, whether of social, economic or political connotation. It means, first of all, that we shall be thoroughly informed, and accurately, in all the phases of the questions under discussion and that we shall be brave enough and fair enough to face the truth which comes out of knowledge. Whether this inures to our material advantage, or not, must be of secondary importance."

Further, he declared:

"* * * What would appear to be perfectly evident, however, is that under our political and legislative system it will always be necessary for medical organization to be actively interested and represented in governmental activities of manifold kinds; not in our own selfish interest but in order that we shall be able to respond to the responsibilities that we are obliged to carry as those most fully informed concerning what is best in the public interest, with regard to health and the treatment of disease and injury.

"* * * There is every reason why medical organization shall apply its energies to the solution of the questions and the difficulties that are involved, realizing that nothing is settled until it is rightly settled.

"* * * I am, however, thoroughly convinced that our profession ought to be represented in the political activities of the country to a degree far beyond that which is the case at present; for the greater good of the country, however, and not simply for the profession."

There we find the suggestion that medical organization must study these problems; collect accurate and authentic information upon them, and after it has digested this information, formulate definite and firm policies which must be backed by the concerted interest and activity of the medical profession generally.

But, how shall the attitude of medical organization toward these social, economic and political questions be crystallized?

What must medical organization do in an active way to protect the ideals of medicine, safe-

guard the public health, and educate the public in medical matters in accordance with sound, constructive, sane and concerted medical thought?

By developing efficient and capable leadership in the medical profession and stimulating leadership of the medical profession in activities dealing with medical and health questions, Dr. Freiberg believes.

"It may be regarded as axiomatic that wherever mass activity or interest is concerned," he stated, "a group must either lead or be led.

"I believe that there is no third possibility. The lead in all things with which medicine has close contact and in which medical science or practice plays the vital role should be taken by medical organization and through representative members. Failure to do this will imply, to the public, either a disbelief in the dicta of our own profession or a lukewarm attitude toward the public good. In either case, it will militate against the acquisition of the place of influence which our profession should have in order that its beneficent mission may be fulfilled. We must develop leaders from our own ranks; leaders who are broad minded medical men, capable, public spirited and willing to serve. We must find such leaders in every constituent and component society; and in each of these, men able to assume the directive role in each of the three classes of activity with which I have dealt in this discussion. Having found them, we must support them devotedly and with enthusiasm so long as they are truly representative of the ideals which we proclaim as ours. Thus only, I believe, will medicine assume the place in public esteem which it deserves; thus only, can medicine serve humanity as I verily believe it is destined to do."

Annual Meeting Gets First Call

With the thought in mind that the year 1932 will bring forth many vital and complex developments, having a far-reaching effect on the practice of medicine and commanding the active, and united interest of the physicians of Ohio, individually and as an organized group, members of the State Association may at this time begin making arrangements for attending the 86th Annual Meeting to be held in Dayton, May 3 and 4.

No gathering of the medical profession to be held in Ohio during the year will offer a better opportunity for the review, study and discussion of many of the important medico-social questions now confronting the medical profession; the formulation of programs and policies for coping with the perplexing problems of vital concern to physicians, as well as the public, and the strengthening of organized effort and activity on the part of the medical profession, in addition to the splendid advantages afforded each physician in attendance for adding to his scientific knowledge.

Preliminary plans and arrangements for the Dayton meeting are rapidly being completed, under the general direction of the Council Committee on Arrangements, composed of Dr. E. M. Huston, Dayton, chairman; Dr. H. S. Davidson, Akron, and Dr. I. P. Seiler, Piketon.

Various committees of the Montgomery County Medical Society have been at work for some time on local details and arrangements incidental to the annual meeting under the general local chairmanship of Dr. A. W. Carley, and the President of the Montgomery County Medical Society, Dr. Fred K. Kislig. Arrangements have been made for holding the 1932 gathering at the Biltmore and Miami hotels. The Biltmore will be the headquarters hotel and will house the registration headquarters and exhibits, and will be the meeting place for most of the general and scientific sessions. Meetings not scheduled to be held at the Biltmore will be held at the Miami in close proximity to the headquarters hotel.

Personnel of the various Dayton committees handling local details for the meeting is as follows:

Reception—Drs. H. H. Herman, chairman, L. G. Bowers, Robert C. Austin, H. V. Dutrow, A. F. Kuhl, M. R. Haley, Clarke C. Sullivan, Homer D. Cassel and Benedict Olch.

Entertainment—Drs. C. H. Tate, chairman, B. W. Beatty, R. A. Lewis, Sterling H. Ashmun and Mack Shafer.

Stereopticon—Drs. Harry Burnett, chairman, C. D. Fife, F. L. Shively, J. D. Fouts, W. B. Taggart, F. C. Payne and James Sagebiel.

Halls—Drs. C. R. Weis, chairman, N. C. Hochwalt, Ben Suffron, Leo Schram, W. S. Powell, H. L. Strohmeyer, E. J. Duffey, R. C. McNelly, Alex C. Rab, T. E. Newell, E. A. Sherk, T. K. Kirk, Fred P. Bucher and Orville Burke.

Exhibits—Drs. D. C. Conklin, chairman, H. F. Koppe, R. K. Finley, Henry Snow, C. D. Smith and J. K. Hoerner.

Scientific Exhibit—Dr. Walter Simpson, Chairman.

Several features to augment the official program for the two-days meeting are being contemplated by Dayton physicians for the benefit of those attending the Dayton gathering. Tentative plans are under way for the holding of medical and surgical clinics at various Dayton hospitals and medical centers on the day preceding the annual meeting and for a scientific exhibit during the annual gathering. As usual, the Ohio State Medical Golfers' Association will stage its annual tournament on Monday, May 2, immediately preceding the annual meeting.

Under the direction of the Council Program Committee, consisting of Dr. H. M. Platter, Columbus, chairman, Dr. John A. Caldwell, Cincinnati, and Dr. S. J. Goodman, Columbus, secretary, details for the sectional and general sessions of the meeting are being completed.

Officers of the various scientific sections have been prompt and diligent in whipping together the programs for the sectional meetings, all of

which promise to be unusually interesting and attractive.

Special effort has been put forth by the Council Program Committee in arranging the programs for the general sessions. One of the innovations in this connection will be the co-ordinated symposia given by the three Class A medical schools in Ohio—Western Reserve, University of Cincinnati and Ohio State University. This feature, which will be presented at the General Scientific Session on Wednesday afternoon, May 4, will consist of three forty-five minute presentations, one by each of the three schools, on timely scientific work to which the school is devoting particular attention. Tentative outlines of the symposia indicate that this scientific attraction will be of general interest to all physicians, especially to general practitioners.

Several changes have been made by the Program Committee in the customary set-up and schedule for the annual meeting events, which, it is believed, will produce a more satisfactory arrangement for the greater portion of those in attendance. The time for the Organization Luncheon has been set for Tuesday noon instead of Wednesday noon, as heretofore, providing, it is thought, a more opportune time for the holding of this important event and relieving the congestion in the final day's program. The final session of the House of Delegates will be held on Wednesday afternoon, as usual, but will start at 3:30 p. m., instead of 1:30 p. m., in order to give members of the House of Delegates an opportunity to attend the General Scientific Session which will get under way at 1 p. m. Wednesday.

Additional information on all phases of the Dayton meeting will be furnished in later issues of *The Journal* when members also will be supplied with data on the Dayton hotels—their location, rates, etc. The prospects are bright for a beneficial, interesting and helpful gathering in the Gem City.

Dependency, Pauperization, Social Insurance

England, with all its efforts—some of them of doubtful value—to improve the health of its population, is at present endeavoring to find out why it is that claims of illness under the socialistic, or paternalistic and costly National Health Insurance Act have increased by 60 to 100 per cent during the past five or six years, a figure entirely out of proportion to the increase in unemployment and of other unfavorable social and economic factors.

While statistical studies for the past two or three years have not been completed, there is every indication, in the opinion of administrators of the insurance act, that the experience of the years 1921-1927 inclusive will be duplicated. Between 1921 and 1927, the claims of male workers of a group of 500,000 insured persons studied, increased 41 per cent; those of unmarried women 60 per cent, and those of married women 106 per cent. It was shown that in 1921, 14 out of every 100 men claimed sickness benefit; in 1927, the proportion has risen to 23. Among unmarried women the respective proportions were 12 and 21, and among married women, 19 to 38.

The answer to Great Britain's inquiry seems apparent to some who have watched from a distance the development of her gigantic systems of social insurance, pensions, doles, etc.

Through its efforts to relieve suffering, poverty and illness and to correct social and economic conditions by unsound and superficial means, England has increased dependency; opened the gates to malingering and fraud; advanced the fallacious principle of paternalism, and established enervating systems of pauperizing the people by government subsidies. England has permitted itself to be riddled with socialistic theories and systems resulting in wholesale raids on the national treasury for unsound and ill-advised programs and in the rearing of a new generation of citizens, lacking in self-reliance and the desire and will to carry on their personal affairs without government help and supervision.

Developments in the United States during recent years strongly indicate that America must not fail to heed seriously the predicament in which England finds itself.

Organized pleas for government subsidies and government supervision, as well has vigorous demands for federal and state support of this, that and the other program or project designed as a cure-all for so-called social and economic evils have become political issues here and are mustering an alarming amount of support among the unthinking portion of the public.

As one observer has well described the present trend in this country:

"It would almost seem that in our country now there is a wish to turn the printing presses of the United States over to the manipulations of the demagogues of the country to be used for the amelioration of every whipper-snapper that appears with a plan to set the country on its financial feet firmly.

"Without in the least magnifying the distress in the world, one is brought to the conclusion that an effort is being made to cure the case without making a diagnosis of the causes of the ailment. It is an unfortunate fact that men and women will answer the call of their country and will suffer untold hardships and even death for the sake of the honor and preservation of their country, but they will not live within their incomes for the same idealic purposes.

"There is a well-grounded fear in this country by those who watch the trend in government here that we are hastening toward the enervating sys-

tem of pauperizing the people by government subsidies in a thousand and one ways.

"This constitutes one of the most socialistic trends in our government today. This nation has become accustomed to look to the conservative element to act as a check to this socializing of the American system of government. But the ranks of the conservative element are coming to be honeycombed with the socialistically inclined and differentiation is becoming harder and harder."

"Apparent" Excessive Death Rates

Contradicting assertions that the United States experiences the highest maternal mortality rate in the civilized world, Dr. Andy Hall, state director of health of Illinois, in a recent statement declared that the apparently excessive rate in this country results from a more accurate diagnosis of illness and a greater fidelity in classifying records. Any other interpretation would be a serious indictment against the public intelligence and against the integrity and qualifications of the medical profession of the United States, he said.

"Our physicians," declared Dr. Hall, "are as well qualified as any in the world and superior to most. Nowhere are the hospitals superior to those in the United States. Our nurses are the equal of those found in any other country and far better than the great majority elsewhere. Our people have a higher intelligence level than any other nation. Our general health conditions are more favorable than those prevailing in foreign countries. Under these circumstances it is preposterous to contend that the United States loses more mothers to the complications of childbirth than do other countries.

The practice of statisticians in this country is to charge against the complications of child birth practically all deaths which occur in connection with that event. Even if pneumonia, for example, is the immediate cause of a maternal death at about the time of childbirth, the fatality is charged against a complication of reproduction on the theory that pneumonia might otherwise have been avoided.

"In many foreign countries the practice is the reverse. Every excuse is used for charging maternal deaths to some other cause than the complications of childbirth. In England, influenza is invariably recorded as the cause of death if this illness attacks a mother about the time of a childbirth.

"An analysis of the Illinois statistics indicates that even the Federal statisticians lean unduly toward childbirth as the main factor in maternal fatalities. The Federal statistician always finds an excuse for charging a larger number of deaths to these causes than does the State statistician. The same is true of the relation between other States and the Federal statisticians.

"If our maternal death rate appears to be higher than those in foreign countries it is because we prefer to err on the side of honesty."

Local Problems—Local Solutions

As to the results so far of the current economic depression, one of the few bright spots of the unsettled condition of affairs has been the widespread protest against nationalization of community relief work or the entrance of the federal government into all sorts of social insurance and benefit schemes in an effort to restore business and save the country.

Constant and persistent efforts have been made and powerful pressure is now being brought to bear on the national administration and those closely alligned with it to have the government at Washington step in and inflict on the American public some of the practices and schemes that have proved impractical and unsuccessful in England, Germany and other European nations.

However, as yet, sponsors of those foreign theories and plans have met with little, if any, success, which seems to indicate that the American public still is fairly well immunized against paternalistic and communistic diseases.

One of the latest failures of those who believe the federal government should take over the affairs of local communities is reported in *Nation's Business.*

"Mayor Hoan of Milwaukee," that periodical states, "has been writing to the mayors of other cities asking that they all join in a movement to urge President Hoover to call an extra session of Congress to enact legislation for unemployment relief.

"The Milwaukee mayor is not meeting a unanimous chorus of approval. He has been told at least twice by New England mayors that they didn't care for federal aid or interference in their problems.

"Mayor Tully of New Haven told the mayor of Milwaukee that New Haven would care for its own unemployed and that other cities would do well to follow its example.

"Mayor Batterson of Hartford wrote:

" 'The city of Hartford doesn't want the Federal Government to help it in any way, shape or manner, save in making such accommodations as are necessary for housing Federal employes. Otherwise, we're going to pay our own way. We say this, knowing that this is going to be far less expensive for us to deal with our own people than to have the Government who does not know them, deal with them.'

"New England, the home of the town meeting, apparently intends to keep on minding its own business."

Burns, and Their Treatment: A Review of Three Hundred and Fifty-Two Cases

ABRAHAM STRAUSS, M.D., Cleveland, Ohio

A burn is an injury inflicted on the body by a degree of heat higher than that compatible with healthy action in the part affected.

The causes of burns may be listed as

Thermal—

Dry—such as fire, powder and hot metals

Moist—as scalds (liquids, molten metal.)

Physical—

Electrical, sun, *X*-ray and radium.

Chemical—

Burns resulting from explosions introduce a mechanical violence.

We are concerned in this discussion primarily with burns resulting from fire or from scalds. Clinically, it seems best to classify burns as follows:

First degree—those that show erythema.

Second degree—the formation of vesicles.

Third degree—destruction of epidermis and part of the dermis.

Fourth degree—charring.

Usually the degree of the burn is in proportion to the degree of heat of the agent and the length of time of application.

First degree burns are almost never hospital cases. If brought to the emergency room of the hospital some soothing substance such as carron oil or boric ointment is applied and the patient is then allowed to go home.

The more severe grades of burns require our attention and often our most ardent efforts together with the most careful nursing.

With second degree burns the epidermis is raised in places by an exudation of fluid from the papillary layer of the dermis leaving the germinative layer attached to the dermis. However, in more severe burns a bulla may be formed by fluid separating the entire epidermis from the dermis. Regeneration takes place without scar formation when the corium is not destroyed. These burns generally heal without skin graft.

Any burn that destroys all the layers of the epidermis and part or all of the dermis are third degree burns. If not too deep they may heal by the growth of epithelial cells from sweat gland or hair follicle cells. Otherwise, granulations arise and the only epithelium able to cover the defect is that which borders the granulations. Skin grafts in some form are often necessary to supplement healing from the periphery.

I may say that we have no case of charring that survived.

Read before the Surgical Section, Ohio State Medical Association, at the 85th Annual Meeting, Toledo, May 12-13, 1931.

From the Surgical Service of Mt. Sinai Hospital, Cleveland.

There are many pathological conditions found distant from burns. It must suffice here simply to mention congestion of the cerebrospinal system, thrombosis in pulmonary vessels, degenerative changes in the kidney, congestion and decrease of lipoids in the adrenals, degenerative changes in liver and spleen, and the rare ulcer in the stomach, and hemorrhages in the intestine. None of these, however, are pathognomonic of burns. Therefore, we are more concerned with the immediate general reaction of the burned patient than with these remote pathological changes. It is the causes of early death such as violent shock and toxaemia which we must treat in order to lower the death rate.

Investigations have ruled out the theory that death is due to interference with the normal function of the skin and have left us with two theories.

First, that there is a toxic product absorbed by the blood from the burned area and that this may be eliminated at least in part through the kidneys. As a result of many experiments the following substances have been found either in the blood or urine of burned animals or patients, and each in turn has been considered the cause of death.

Toxin resembling abrin and ricin (Stengel and Fox)
Methyl guanidine (Kutcher and Heyde)
Pyridine base (Reiss)
Tyramine
An uraemic-like poison (Pfeiffer)
Muscarin (Lustgarten)
Ptomaines like snake venom (Parascandolo)
Histamine
Toxalbumin (Dorrance and Bransfield)
Peptotoxins (Kijanitzin)
Split protein products (Fraenkel and Spiegler)
A nonprotein intracellular toxin (Truck)
A thermolabile necrotoxin and thermostabile neurotoxin (Pfeiffer; Robertson and Boyd)
Albumoses (Heyde)
Anaphylaxis
A toxin from blood altered at site of burn (Ferrarini).

Sauerbruch and Heyde also Vogt joined two dogs by abdominal flaps to prove that a toxin was carried by the blood stream. One animal of the pair was burned and both died with the same symptoms.

Another experiment to prove that the toxic substance was formed at the site of the burn consisted of removing the burned skin and transplanting it to another animal. The recipient died whereas the donor lived.

Ferrarini however says that there is not sufficient evidence to prove that statement but that the blood at the site of the burn may be so altered that when absorbed it is toxic.

The other theory that attracts our attention deals with the changes in the composition of the blood. There is a temporary increase in coagulability of the blood but this changes to an incoagulable condition in fatal cases. There is some distortion and fragmentation of the cells and an increase in leucocytes. Further examination reveals an increase in nonprotein and urea nitrogen, a loss in chlorides and sometimes a rise in creatinin and sugar content.

Pfeiffer found a relative increase but an absolute decrease in the number of red blood cells and the amount of plasma. Finally, Underhill concluded that the concentration of blood is an important factor in the fatal course of a burned patient. This concentration is due to the outpouring of fluid from the blood plasma at the site of the burn. "Concentration of the blood means a failing circulation, an inefficient oxygen carrier, oxygen starvation of the tissues, fall of temperature and finally suspension of vital activities". He points also to the rise in temperature of the viscera causing direct damage to the internal organs.

The severity of the symptoms varies with the intensity of the heat and the size of the area affected. It is usually considered that a second degree burn will be fatal if two-thirds of the body is affected but that only one-third of the body need be burned for a third degree lesion to be fatal. Berkow has formulated a plan by which one can estimate the amount of the body surface burned.

PARTS	PROPORTIONS (PER CENT) (BERKOW)	
Head & Neck	6%	
Trunk	38%	
	Anterior Surface	20%
	Posterior Surface	18%
Upper Extremities	18%	
	Hands 1/4 of Total	
	Arms 3/4 of Total	
Lower extremities	38%	
	Feet 1/6 of Total	
	Legs 2/6 of Total	
	Thighs 3/6 of Total	

Burns of the face, mucous membranes and genitalia always add to the gravity of the case.

The patient when first seen may be in shock, suffering great pain, restless, chilly with subnormal temperature, rapid feeble pulse, rapid respiration. If the patient is a child, vomiting and convulsions are common. The expression is anxious, the pupils dilated.

If the patient survives the shock of the first twenty-four hours his course of illness will depend on his resistance and the efficacy of the treatment to overcome the subsequent toxaemia. Nursing is a most important factor in the success or failure of the treatment.

In this period the temperature starts to rise rapidly to 103 or 104. Pulse and respiration rise with it. This is the time when strenuous nursing is important. Fluids must be pushed to 4000—6000 cc. in twenty-four hours for adults and for children in proportion. The urine may contain casts and albumin varying from slight trace to very heavy precipitate and the output may be diminished almost to zero.

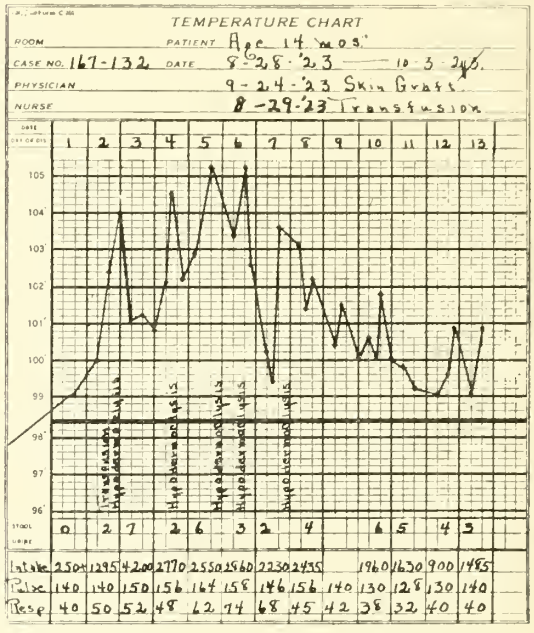


Fig. 1. Case 132. Severe Toxaemia. Diarrhoea. Transfusion. Hypodermoclysis. Skin graft. Recovery.

At this time the changes in the blood chemistry above noted take place.

The temperature, respiration and pulse begin to drop as the toxaemia is overcome. The blood chemistry and urinary output become normal. Unless infection occurs the patient is on the way to recovery and all that remains is to heal the defects. If the granulating surface is infected septic fever occurs. This may cause gradual inanition and anemia and lead to other complications such as pneumonia, otitis media, or septicaemia which may or may not prove fatal. Transfusions are often necessary to improve the general condition of the patient under such circumstances.

Thus we can look back at the symptoms of our burn sufferer and explain them in this manner.

The patient brought in with extensive burns is in a state of shock probably because the blood is concentrated to a degree incompatible with life.

The one who is less burned or who survives this period may die later because, as we have said before, of the absorption of split proteins or other toxic substances that cause changes in the parenchymatous organs.



Fig. 2. Shows tannic acid precipitate on extensive burn.

With this picture in mind we have a guide to the therapy that is required. First: treat the shock and the concentration of the blood by warmth, stimulation, fluids (subcutaneously, intravenously or by rectum), and morphine for pain. If the patient survives the first twenty-four hours the temperature will indicate the absorption of toxin by a rise. The output of urine will be diminished and the urine may or may not contain albumin and casts. The blood chemistry will show nitrogen retention. This is a signal to pour more fluids into the circulation and for that I have not yet given up the exsanguination transfusion of Robertson and Boyd. It is well to point out that the only way to bleed an infant or a child is to pass the needle or cannula through the saphenous into the femoral at the fossa ovalis. If this site is destroyed one must use the jugular. The cubital vein is not sufficient. The early transfusion and exsanguination transfusions may react not only by diluting a circulating toxin but by destroying or binding it to some extent. In that way it may be better than the intravenous glucose. Nevertheless we have lately added the method of withdrawing some toxins from the blood and diluting the rest by the continuous venoclysis of 5 per cent glucose.

The burn itself when first seen should be made clean. Blisters should be opened and dead skin cut away and then treated like the third degree burns. Without a doubt the best dressing is fresh sterile 5 per cent tannic acid sprayed on from an atomizer until a black precipitate is formed. This is of course the method of Davidson. This precipitate becomes firm and fixed. The wounds are then left exposed to heat. It is our custom to place children with burns on sterile sheets under a tent or cradle warmed with electric lights. This method has superseded all ointments and ambrine and solutions. The precipitate is allowed to remain until it peels off by itself. (Fig. 2.)

If an infection has occurred the precipitate is removed after applying compresses of warm potassium permanganate or Dakin's solution.

When the crusts have been removed attention is directed toward getting the granulations clean enough for skin grafts. If the area is not too large Thiersch grafts are preferred. The more extensive areas are covered either by Reverdin grafts laid on the surface or by pinhead size Thiersch grafts imbedded in the granulations after the method of Braun.

The earlier the skin grafting is done the less contraction will be found in the resulting scar. These contractions can not always be prevented but an attempt should always be made to fix the limbs in such a position as will prevent contractions and adhesions. With very extensive burns some form of skin flaps may be necessary to cover the defects. (Figs. 3, 4, 5, 6.)

Some scars result in keloids which may be troublesome for months because of itching.

A late complication not infrequent in an extensive scar from a burn is an indolent ulcer which if untreated may finally change to an epidermoid carcinoma.

DIAGNOSIS

There is very little need to discuss this phase because it makes little or no difference in treatment whether the destruction is due to a scald or to dry heat.

When the skin is scalded it has an ashy hue, a sodden appearance. It is never blackened and the hairs remain untouched. A burn from fire on the contrary causes a blackened dry skin. The hairs are scorched and there is a distinct burnt odor present.

This report is based on a series of 352 cases (Table I) treated at Mt. Sinai Hospital, Cleveland from 1916 to 1931. The largest number occurred between the ages of one and six. Note that in this group of 92 cases the females predominate as also in the older patients beyond 50. In the



Fig. 3. Case 167-60, July, 1926. Third degree burn face, neck, chest, arms. Contractures after healing by Reverdin grafts.



Fig. 5. Case 167-60. End result, April, 1931.



Fig. 4. Case 167-60. Shows pedicle flap to neck from back. Base still attached.

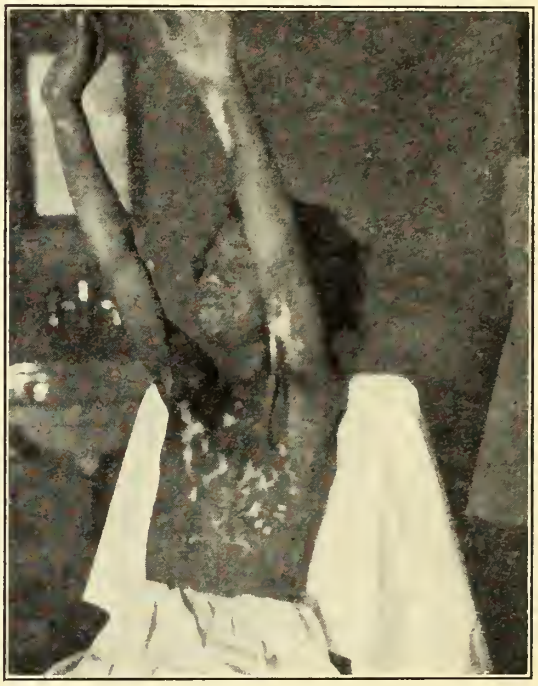


Fig. 6. Case 167-60. End result, April, 1931.

TABLE I

Age	Under 1 year	1-5	(Incl.) 6-10	11-20	21-30	31-40	41-50	51 +	Total
No.	11	92	35	38	55	52	34	35	352
Male	6	36	19	21	34	35	19	13	183
Female	5	56	16	17	21	17	15	22	169
Scald	9	43	5	5	14	11	7	3	97
Fire		44	29	25	30	34	24	26	212
Electric		2			5	1	1	1	10
Chemical	1	1		4	4	2			12
Hot metal	1	1		3	2	4			11
Death	2	23	6	2	1	7	7	10	58
Mortality % in age groups.	20	26	16	4	1.8	13	20	28	

age groups that include the working ages industry accounts for the preponderance of males injured by burns. Furthermore the burns are so severe between the ages of one and six that the death rate is 26 per cent, second only to the severe burns in the aged.

The youngest in this series was seven weeks and the oldest was aged 88. Nine of the eleven cases under one year of age were scalds, one was a chemical burn, and one was due to a hot metal plate. Fire which was the predominant agent in all other ages, never was the cause in these infants under one year.

The complications met with in this series were two cases of tetanus, four of laryngitis, one serum reaction, one scarlet fever, one septicaemia, and three otitis media. Transfusions were resorted to in fifteen cases with six deaths. Exsanguination transfusions were used in nineteen cases. Of the latter there were five deaths. I wish to emphasize that these fourteen that survived may owe their recovery in a great measure to that form of treatment which was used when the patient showed signs of toxic absorption.

Grafts were used in twenty-seven cases, pedicle flaps were necessary in only two.

It is interesting to note that of the eight autopsies performed four showed the typical picture of status lymphaticus. It is well recognized that toxaemia is one of many conditions regarded as a cause of status lymphaticus, and it is therefore little wonder that this end result should be found at the autopsy of a burned patient.

It is not possible to quote figures in this series to show whether one form of treatment was better than another because the records are not complete enough. Furthermore, there is no one fixed method of treatment applicable to all burns.

However, those of us who have paid special attention to the burned patient are agreed that 5 per cent tannic acid sprayed on the wounds till a precipitate is formed is the best dressing whether or not it aids in preventing toxic absorption. Another reason for our improved results is that we are introducing more fluids into the patient to combat the toxaemia and the concentration of the blood. But I believe that transfusion with or without exsanguination is an aid that cannot entirely be displaced by infusions.

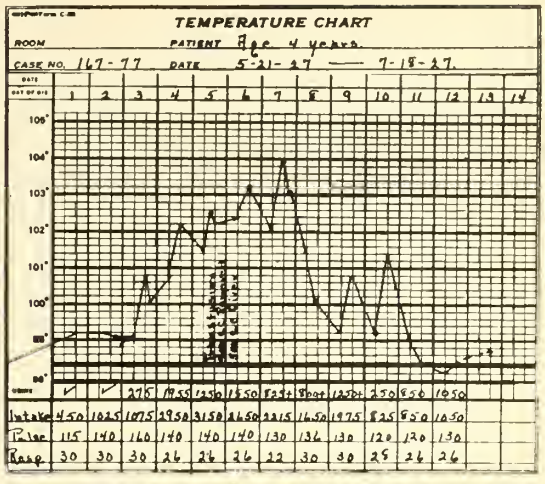


Fig. 7. Case 77. In shock two days. Suppression of urine. Toxaemia and rise of temperature third day. Exsanguination tranfusion fifth day. Recovery.

Figure 7. Case 77 is that of a four year old child admitted in a state of shock. It was more than twenty-four hours before the temperature started to rise. There was no infection to account for the fever. This gives support to the theory of Robertson and Boyd who stated that this is a sign of the absorption of the toxin and tends to controvert Underhill who pointed to his animal experiments as showing no late definite rise and who discounts the theories of toxaemia. In my own experiment, my animals died from infections and not from toxaemia. On the other hand, my clinical experience has shown me that with few exceptions death from burns is due to something other than infections.

In conclusion I wish to emphasize that as a result of a severe burn either from fire or from a scald the patient may die in the first twenty-four hours from shock or seven to fourteen days later from a toxaemia due to some toxin or changed condition of the blood. Absorption of these products brings about degenerative changes in the parenchymatous organs. When death occurs later it is usually due to some complications.

The important points to remember in the treatment are: First, to treat shock. Second, to cover the wound with fresh sterile 5 per cent tannic acid sprayed on until a precipitate is formed. Third, to keep the patient warm under some form of heated tent. Fourth, to force fluids by every known method to get 4000-6000 cc. per day into the system. Fifth, to use transfusion and exsanguination transfusion as valuable methods combatting toxaemia. Sixth, to skin graft as early as possible to prevent contractures. Seventh, to use prophylactic positions also to prevent contractures.

1623 MEDICAL ARTS BLDG.

DISCUSSION

SIDNEY MCCURDY, M.D., Youngstown:—I wish to thank Dr. Strauss for bringing me up to date again upon burns. It really seems strange to me

that we know so little about burns after the great number of years that the human family must have suffered from them. No agreement seems to have been reached when we scientifically study what occurs as the result of these burns. Some have thought that the trouble was a disturbance of the functions of the skin, and others that faulty heat regulation was caused. Some think that blood changes such as diminished coagulation time and concentration of the plasma were at fault. Others felt that we were dealing with the toxic effect of digested protein and its by-products. Morehead of New York still uses bicarbonate of soda solutions 10 per cent in the treatment of his burns. This treatment may have some justification since intracellular digestion of protein is accomplished better in a fairly acid medium than in an alkaline one. Shock, which is so often met with in severe burns, must be treated with the appropriate surgical means.

A classification of first, second or third degree burns means little to me in a practical way. I classify burns into two classes, whether ambulatory or not.

In industrial work we cannot use the tannic acid treatment of Davidson in ambulatory cases, since we cannot control the treatment. For our hospital cases we most often do use it.

Ambulatory cases with us are cleansed and for small superficial burns boric ointment or paraeusol, an antiseptic solution of salicylates in oil, are satisfactory. The more severe cases that require hospitalization are usually treated with tannic acid, morphine always being given to allay the pain and diminish the shock.

We have found, we think, that tannic acid, freshly made, 5 per cent to 10 per cent is most efficient in burns that may be considered fairly clean such as steam and hot water burns. Burns caused by explosion when it is clearly evident that dirt has been forced into the tissue, we do not treat with tannic. Tannic acid treatment begins in the emergency hospitals with the first dressing, and there we saturate gauze with the solution and bandage the patient. At the base hospital the patient is placed under a frame covered with sterile bed clothes and the interior kept warm with electric lights. The patient may be treated with no dressings or the original ones left on. If the dressings are used they must be sprayed frequently. Usually at the end of twenty-four hours all dressings and spraying is finished since the albumin is now coagulated in the form of a hard crust covering over the burned area. I do think this is the best treatment yet since absorption is diminished and pain decreased. Often infection does occur as evidenced by rising temperature and pulse when this tan must be opened and removed for drainage. We do not put tannic acid on the face but use our antiseptic oil, paraeusol.

There are preventive measures which should be used by those working in industry. In our tube mills we have available, blankets to smother the fire upon a burning person. In our acid departments we have special means to flush the burned persons with plenty of water.

I would suggest that it is quite within the scope of the interest of this section to inaugurate a complete study of burns and for once standardize the knowledge concerning their pathology and treatment. Again I thank Dr. Strauss for his excellent discourse on burns.

The Role of the Autonomic Nervous System In Endocrine Disturbances Relative to the Eye

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THE autonomic nervous system in its relation to ophthalmology consists of:

A—A sympathetic system, the function of which influences the:
- 1—Dilator muscles of the iris.
- 2—Lacrimal gland.
- 3—Extrinsic ocular muscles including the superior tarsal muscle.
- 4—Smooth muscles of the orbit.
- 5—Blood vessels of the orbit.

B—A parasympathetic tract, the function of which affects the:
- 1—Constrictors of the iris.
- 2—Muscles of accommodation.

SYMPATHETIC ANATOMY

There is varied opinion as to the center of control of the sympathetic eye mechanism. Karplus and Kreidl (1909) found that by stimulating the region of the hypothalamus sympathetic action on the part of the eye was induced. This also demonstrated reaction on the part of the lacrimal, salivary and sweat glands.

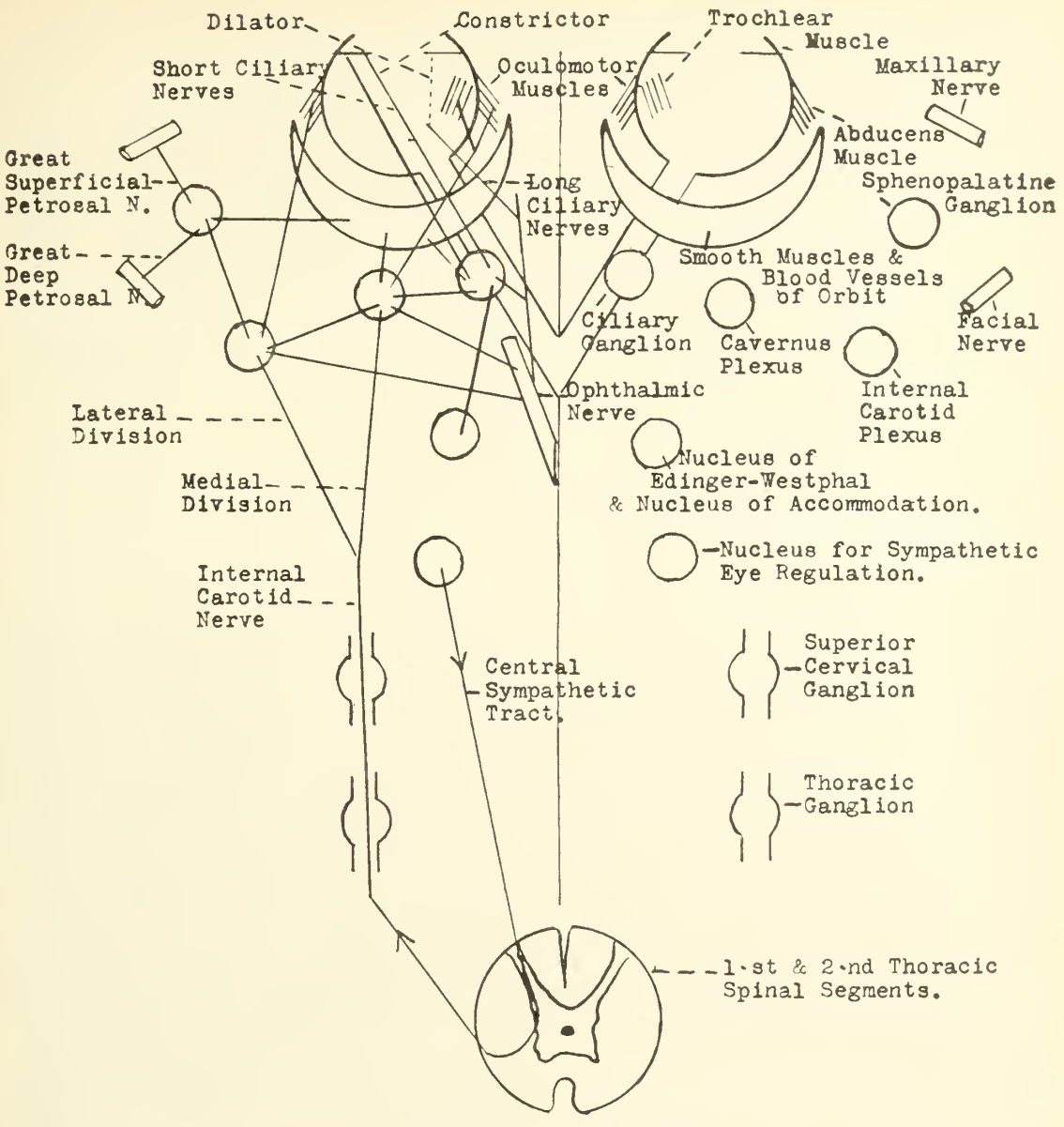
William Keiller places the nucleus for this control in the reticular grisea of the medulla oblongata.

From the nucleus, tracts, as yet not definitely located, descend through the medulla and cervical cord, apparently without crossing, to the cells of the seventh cervical and first and second thoracic segments, which, in turn, send rami communicantes along the emerging first and second thoracic nerves to the superior thoracic ganglion. This ganglion relays rami upward to the superior cervical ganglion. Thence by way of the internal carotid nerve the sympathetic fibers divide into a lateral division which continues to the internal carotid plexus, and a mesial division which proceeds to the cavernus plexus.

The internal carotid plexus communicates with the sphenopalatine (Meckel's) ganglion by way of the great deep petrosal nerve which joins with the great superficial petrosal nerve of the facial to form the nerve of the ptergoid canal (Vidian).

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From the Department of Anatomy of the University of Cincinnati.



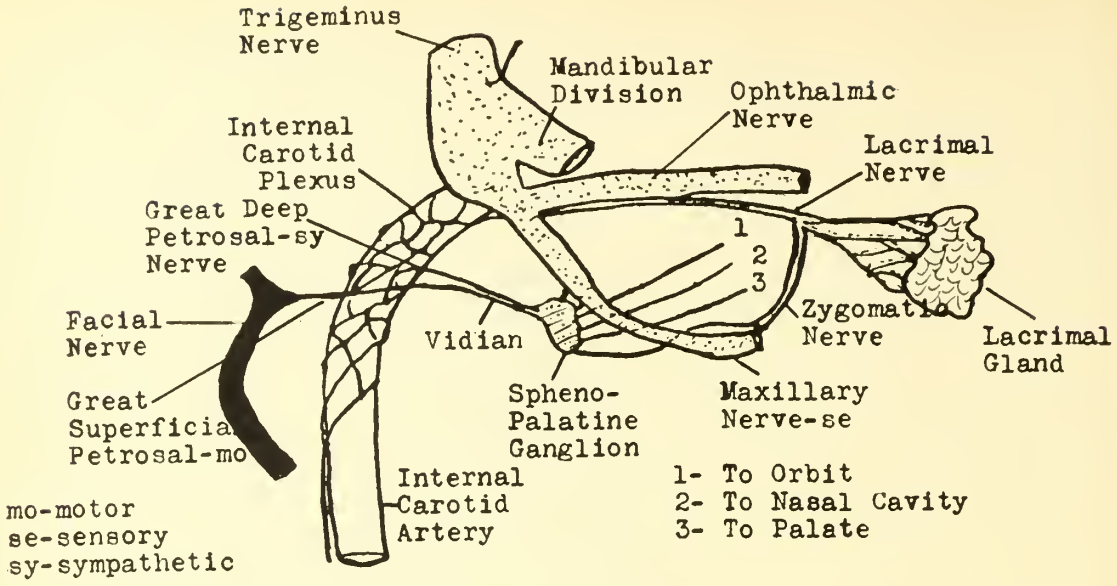
The Autonomic Nerve Supply to the Eye.

The motor component of this ganglion is from the maxillary division of the trigeminus. The ganglion sends several orbital rami to smooth muscles and blood vessels and to the periorbitum. Some authors believe that through these rami the lacrimal gland receives its motor secretory supply.

The internal carotid plexus sends rami to the trigeminus, which, proceeding with its ophthalmic division, continuing with the naso-ciliary branch, to the ciliary ganglion in passing, supply the sensory innervation to the eye, the long ciliary nerves. Some believe the long ciliary nerves are purely sensory, others, that they also convey fibers with dilatory action on the pupil.

The external rectus muscle is supplied by the internal carotid plexus. The cavernus plexus supplies the extrinsic muscles of the oculomotor nerve and the trochlear nerve. Together with the internal carotid plexus it also supplies the smooth muscles and blood vessels of the orbit. It relays fibers to the ciliary ganglion. Rami also proceed from the cavernus plexus to and along the ophthalmic nerve and naso-ciliary nerve.

The ciliary ganglion is composed of sympathetic fibers from the cavernus plexus, sensory and sympathetic fibers from the nasociliary nerve, and para-sympathetic fibers from the nucleus of Edinger-Westphal along with oculomotor fibers of the third nerve. The ciliary ganglion gives off the short ciliary nerves to the constrictors of the pupil and the ciliary muscles of accommodation, and the sympathetic rami to the dilators of the pupil. It also helps to supply the smooth muscles and blood vessels of the orbit and the extrinsic ocular muscles.



Nerve Supply of Lacrimal Gland.

PARASYMPATHETIC ANATOMY

In the floor of the Aqueduct of Sylvius at the level of the superior colliculus is located a group of nuclei of the third cranial, the oculomotor nerve. These component nuclei are divided into one small lateral (superior) nucleus of Edinger-Westphal, one small medial nucleus the center for accommodation, and a large lateral group of nuclei controlling the extrinsic ocular muscles, excepting the external rectus and the superior oblique, through their respective fibers in the oculomotor nerve.

Of this group we are interested in those nuclei that control smooth muscle, the intrinsic ocular muscles of the iris and the ciliary body. These are the small lateral and small medial nuclei which send their fibers along the remaining components of the oculomotor nerve through the posterior longitudinal fasciculus, which forms a 'V' around the grouped oculomotor nucleus, through the brachium conjunctivum (superior cerebellar peduncle) beyond its decussation, passing medial to the red nucleus (possibly some fibers to or through it), and through the pyramidal tract to emerge from the medial side of the basis pedunculi. The nerve then passes to the orbit: the parasympathetic fibers going to the ciliary ganglion which gives off the short ciliary nerves to the constrictors of the pupil and the ciliary muscles of accommodation.

THE LACRIMAL GLAND

The lacrimal innervation consists of:

1—A sympathetic supply from the superior cervical ganglion.

2—A parasympathetic supply (motor-secretory) from the sphenopalatine ganglion.

3—A sensory supply from the lacrimal branch of the ophthalmic nerve.

As to the course of the sympathetic rami from the superior cervical ganglion to the gland, there is a difference of opinion. The innervation may be either by way of the ophthalmic nerve, thence by its lacrimal branch to the gland which is most likely: or from the superior cervical ganglion to the internal carotid ganglion, and thence by way of the great deep petrosal and Vidian nerve to the spheno-palatine ganglion, then, either by the orbital rami of the ganglion or by way of the lacrimal branch of the ophthalmic nerve to the gland.

The parasympathetic supply is from the facial nerve by way of the great superficial petrosal and Vidian nerves to the spheno-palatine ganglion, thence to the lacrimal gland by either of the courses outlined above.

Secretion of tears is due either to sympathetic psychic excitation, or to irritation of the trigeminus nerve or the optic nerve by intense light thrown upon the retina.

Endocrine glands influence the eyes in two ways:

1—Through their specific hormones by stimulating or depressing the activities of the sympathetic and parasympathetic systems.

2—Through mechanical action the intracranial glands by an increase in size encroach upon adjacent structures, such as the optic chiasm, tract or radiations, or, less frequently upon the nerves of the eye muscles, the oculomotor, trochlear and abducens. It is also possible that an enlarged thymus may exert pressure on the cervical sympathetic system causing stimulation or depression of the sympathetic innervatiton to the eyes.

The functional effect of the endocrine hormones upon the autonomic nervous system is as follows:

Gland	*Secretion*	*Sympathetic*	*Parasympathetic*
Thyroid	Hyper Hypo	Stimulation Relaxation	Relaxation Stimulation
Adrenal	Hyper Hypo	Stimulation Relaxation	Relaxation Stimulation
Parathyroid	Hyper Hypo	Relaxation Stimulation	Stimulation Relaxation
Post. Lobe Pituitary Ant. Lobe	Hyper Hypo	Stimulation Relaxation	Relaxation Stimulation
Ovary & Testes	Hyper Hypo	Relaxation Stimulation	Stimulation Relaxation

The function of the ovary and testes, together with that of the pineal gland, the pancreas (islets of Langerhans), spleen and liver upon the autonomic nervous system are not yet fully established. Other glands having doubtful internal secretions are the prostate, thymus, mammary and kidney.

From this chart it is evident that the sympathetic and parasympathetic nerves innervating the same structure exert an antagonistic action toward each other.

With mechanical pressure, if the contact upon the nervous elements is stimulative (slight increase) or irritative (greater increase), there will be a stimulative effect upon the tract under pressure. If the force is increased so as to inhibit or destroy function the antagonist, being unopposed, predominates showing symptoms similar to its stimulation.

Influence of mechanical pressure on autonomic nervous system:

Lesion	*Nerve Affected*	*Amount of Pressure*	*Sympathetic*	*Parasympathetic*
Intracranial	Oculomotor through Parasymp.	Slight Great	Relaxation Unopposed	Stimulation Destroyed
Cervical	Sympathetic	Slight Great	Stimulation Destroyed	Relaxation Unopposed

Following are the principal symptoms on the part of the eye and upon ocular structures caused by stimulation, or by predominance of the one system, or caused by relaxation or destruction of the other.

Ocular symptoms due to autonomic influence:

Structure	*Sympathetic Stimulation Parasympathetic Relaxation*	*Parasympathetic Stimulation Sympathetic Relaxation*
Pupil	Dilated	Contracted
Palpebral fissure	Widened	Narowed
Lacrimal gland	Increased lacrimation	Decreased lacrimation
Position of Eye in Orbit	Proptosed Exophthalmos	Retracted Exophthalmos
Conjunctivae	Constricted Vessels	Dilated Edema Vessels
Upper Lid	Retracted Lagging	Ptosed Puffy

Complete oculomotor paralysis induces falling of the upper eye lid (ptosis). Sympathetic paralysis due to involvement of the superior tarsal muscle causes narrowing of the palpebral space.

The effect of the endocrine hormones upon the autonomic nervous system may be divided into two syndromes:

1—The Syndrome of Sympathetic Stimulation (Parasympathetic Relaxation). A common example being hyperthyroidism.

2—The Syndrome of Parasympathetic Stimulation (Sympathetic Relaxation). An example being hypopituitarism.

From the mechanical point of view we may have similar to the above syndromes:

1—The Syndrome of Sympathetic Function unopposed by reason of the destruction of the Parasympathetic System. Seen in a destructive lesion in the nucleus of Edinger-Westphal.

2—The Syndrome of Parasympathetic Function unopposed by reason of destruction of the Sympathetic System. Seen in Horner's syndrome.

As stated above the two endocrine glands in direct relation to the brain, the pineal and pituitary, by growth may exert pressure on the optic nerve, or, less often, the nerves of the ocular muscles. Though the tract and even the radiations may be involved, the place that usually receives the pressure is the optic chiasm. The pituitary growth exerts a direct pressure here. The pineal gland by its growth blocks the aqueduct of Sylvius thus interfering with the proper circulation or drainage from the cerebral ventricles, the accumulating cerebrospinal fluid dammed back exerts an increasing pressure upon the walls of the cerebrum (internal hydrocephalus) particularly in the tuber cinereum where the walls are relatively thin, a forward pressure affecting the chiasm and a lateral pressure affecting the optic tracts which are its lateral boundaries. It might be of interest to draw a theoretical anatomical conclusion that the fields of vision from a pituitary growth, being below and behind the chiasm, might show the greatest loss of vision above, whereas a pineal growth exerts its pressure through the tuber cinereum principally from above downwards and forwards with the result that the greatest field loss is in the lower quadrant. However, if the growths are large enough to press the chiasm against resistant structures this sign does not hold. It, therefore, would be seen in early or mild cases only.

Examples of these conditions are found in the:

1—Syndrome of the Hypothalamus.

(Pituitiary Syndrome—Acromegaly)
Syndrome of Marie

The chief features are:

A—Due to anterior lobe involvement:

(1)—Increased bony substance (hyper)

(2)—Delayed sexual development (hypo)

(3)—Degenerative changes in the thyroid gland (hypo)

B—Due to posterior lobe involvement:
(1)—Increased sugar tolerance (hypo)
(2)—Fat deposition (hypo)
C—From both lobes:
(1)—Field changes
(2)—Intermittent headaches.

2—Syndrome of the Epithalamus.
(Epiphyseal Syndrome—Syndrome of Pellezzi or Syndrome of Macro-Genito-Somia-Precox)
The chief symptoms are:
A—Precocious primary and secondary sexual development.
B—Precocious development of sexual function.
(Some authors question the part this gland plays in sexual control).
C—Signs and symtpoms of internal hydrocephalus as:
(1)—Visual disturbances with choked disc or optic atrophy.
(2)—Headaches.
(3)—Vomiting.

909 CAREW TOWER.

Sterility

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IN many instances marriage without the capacity for children proves a great hardship to the united parties, and not infrequently, directly or indirectly, leads to rupture of the home. The importance to the state is also far-reaching, as in many instances those who most desire, and are without children, would produce very capable citizens.

When we more fully understand many of the intricate and obscure causes of sterility, and when birth control is viewed more liberally and even enforced in some instances by the state, then will the home and the state ultimately profit. Ten to fifteen per cent of all present day marriages are sterile. During the past hundred years there has been a decrease in the average number of children per marriage, from five to less than two.[1] This has undoubtedly been partly voluntary, but on the other hand, sterility is increasing, especially among the upper classes.

Compared with the lower animals human beings are notoriously poor breeders. Norris, studying 6000 matings, states that only 3 per cent are fertile after three sterile years. The great majority of first children are born within 16 months of their parents' marriage, and a relative state of sterility exists if there has not been a pregnancy within one year after marriage. The probability of pregnancy decreases very rapidly as the duration of an involuntary sterility increases, and if there has been no pregnancy after five years of marriage there is very little likelihood of one occurring, at least without detection and correction of the cause.

Sterility is either absolute or relative, and in either case may be primary or secondary. In absolute primary sterility reproduction has been impossible always, due to the absence or defects of the essential organs or their functions. Such defects may have developed after a period of fertility, and are then referred to as secondary. In relative sterility which is primary, no fertilization has ever taken place, though if secondary, pregnancy may have preceded the state, and with changed conditions may follow.

Comparatively few persons are absolutely sterile without the reasons being detectable; the absence of the essential genital organs or the physical impossibility of ova and spermatozoa meeting in the fallopian tube. Moench speaks of relative infertility rather than sterility, and since we realize that fertility depends upon both the male and female, and that either one or the other may be temporarily affected by a large number of causes, both genital and constitutional, Reynolds and Macomber have referred to the product of the fertility of both parties compatible for fertilization, as the "threshold of fertility". It is the sum total of the fertility of both parties which affects the fertility lure.

Relative infertility may be transient or permanent in either party, and varies in the same individual from time to time. If both parties are highly fertile, fertilization is quickly attained; if one of the parties is highly fertile, this may overcome a considerable degree of infertility in the other party, but if both parties are relatively sterile, the difficulties in the way of pregnancy are greatly increased or insurmountable.[3]

In a given mating the causes of sterility are usually multiple. They may be all with the male, or the female, or divided between them. Meaker,[4] in a careful study of 50 cases found 10 per cent had no male faults; 5 per cent no female defects. There were 72 male factors, of which 44 were constitutional and 28 local; 160 female factors of which 46 were constitutional and 114 local. One-third of all factors were therefore attributed to the male and two-thirds to the female, and one-third of the combined factors were extra-genital.

Now to discuss the more definitely known

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causes of sterility in both the male and female. As already mentioned, the causes of absolute sterility in both sexes are the congenital absence or surgical removal of the essential genital organs, or complete suppression of their function, so that the initiation of the reproductive process is impossible.

Numerous constitutional causes of low fertility in both sexes are quite parallel and may be discussed together. Glandular dysfunctions and imbalance are common causes of sterility. The normal activity, function, and interaction of the several ductless glands is of great importance, and this is particularly true of both the anterior and posterior lobes of the pituitary, since it is well known that this gland regulates ovarian activity and function. Hormone from the anterior pituitary can hasten ovarian activity without the formation of graafian follicles and ripe ova. The follicular hormone stimulates the endometrium preparing it for implantation of the ova, and the corpus luteum continues this preparation as well as retards further follicular development.

Marked hyperthyroidism in either sex contributes to sterility, but slight hyper-function is of less importance in the female than in the male, where his fertility is reduced and the child frequently of inferior type. Hypothyroidism in either sex is a frequent factor in sterility.

Ovarian dysfunction, as evidenced by hypoactivity with diminished and irregular menstruation, persistent corpus luteum and amenorrhoea, and especially if associated with infantilism, obesity, and atypical secondary sex characteristics, give problems with which it is difficult to cope.

The general health and nutrition of the individuals is very important. Metabolic disorders, negative nitrogen balance where the proteins are deficient, depressed physical states from any cause and especially chronic infections of teeth, tonsils, or sinuses, toxins from which may effect the sperm and ova directly as well as lower the general vitality, are all of etiological importance in sterility.

More is yet to be learned of the importance of vitamins in reproduction. Vitamin E, the reproductive vitamin so-called, found in wheat, peas, lettuce, etc., is essential to the development of the ova. The fetus also needs vitamin A, B, C, and D, and deficiency in vitamin B may lead to abortion or premature birth, and upon its withdrawal, ovulation ceases before nutrition is noticeably affected. Cod liver oil contains vitamins A and D, dry yeast, B and D. Phosphorous and calcium are also necessary to maintain normal metabolism. Vogt[5] recommends the administration of vitamins should be carried out if deemed necessary and especially in cases of repeated abortion.

Malnutrition, constitutional diseases such as chlorosis, anaemia, hereditary syphilis, nephritis, and excesses with tobacco and especially with alcohol, lower fertility and apparently affect young embryos detrimentally.

Variations in blood groups and serological phenomenon do not seem to be of any importance as causative factors in sterility.

Among the more local conditions in the female, several, such as cervical stenosis, anteflexion, retroflexion, hypoplasia, and vaginal acidity, have been, and still are, greatly over-emphasized. It is very improbable that in itself any stenosis or flexion of the uterus can be sufficient to obstruct the ascent of healthy spermatozoa, and in such cases the sterility is much more probably due to other accompanying conditions. Vaginal acidity is also greatly over-rated. The normal vagina always has an acid reaction due to lactic acid, and with local inflammation and increased discharge, the acidity is actually reduced. Brown[6] states that the acidity rarely exceeds 0.5 per cent of lactic acid or an H-ion concentration of 4.7, in which spermatozoa will remain active for hours. The reaction of endocervical secretions is constantly alkaline, Ph. 8.0-9.0, and above Ph. 8.5 in 80 per cent of cases, and this irrespective of age, parity, menstrual cycle, endocervicitis, vicosity, etc.

The Hühner test may show active sperm in the vagina, but if they are unable to penetrate the tenacious mucus which so often obstructs the cervical canal, they will be ineffective. On the other hand, dead sperm may be found in the vagina, though if deposited in good condition they would immediately find their way into the cervical canal and ascending at the rate of 1 to 2 cm. in eight minutes, would be effective and beyond harm in the vagina. This explains the ineffectiveness of certain contraceptives. Normal semen[7] will dissolve cervical mucus by lysis, as also will tubal and uterine secretion, and much may depend on such action, especially at coitus. Soda douches will also remove such obstructive mucus as well as reduce vaginal acidity, though it should be remembered that excessive alkalinity is spermatocidal.

Among the most common causes of sterility are physical obstructions preventing the sperm and ovum meeting in the tube, such as follow salpingitis, oophoritis, polycystic ovaries, cervicitis with thick tenacious mucus from whatever cause, cervical or uterine polyps, and isthospasm. A great help in the diagnosis of such conditions is the Ruben test, especially with the tubal injection of lipiodol.

Uterine fibroids are often associated with sterility. Lynch[8] found 30 per cent of women with such tumors, sterile, with no other apparent cause; 45 per cent, if associated with other conditions; and states that an abnormal number of women with fibroids have pelvic organs below

par. It has often been asked whether the sterility causes the tumors or the tumors the sterility. Miller[1], Harris,[9] and others, find pregnancy follows myomectomy in about one-third of all properly selected cases.

Sterility is probably far less often due to the absence of, or imperfection in ripe ova, than to abnormal spermatozoa, though sterility or early abortion may be due to such inherent defects, incompatibility between them, or unfavorable environment surrounding the fertilized ova. In ferrets, most of the ova are fertilized, but 40 per cent of the zygotes do not develop young.[2] Decidual fitness is imperative for normal implantation, and is dependent upon follicular and corpus luteum influence and proper nutrition. This may be influenced detrimentally by congestion and stasis, the result of uterine displacements, pelvic or uterine pathology, excessive or detrimental sex practices and contraceptive measures. Abnormalities of the chorion, and abnormal environment with poor nutrition to the fetus, lead to very early abortion.

Dittler[10] and others have caused transient sterility in female animals by the injection of spermatozoa, but no such result is seen after very frequent intercourse, nor has it been shown that the serum of such females is spermatotoxic. Such sterility is probably that due to a foreign protein, and its effect on metabolism, or the endocrines, or the ova themselves, as they are especially sensitive to general health. Since we know that the normal sex cycle is dependent upon female sex hormone which is found in the circulating blood, and at least partly eliminated in the urine, Frank[11] suggests that the kidney with a lowered threshold for such hormone, allows its escape before sufficient concentration occurs for the proper stimulation of such functions. There are complicated physiological tests to determine the presence of such hormone in the circulating blood, and these may be of aid in differential diagnosis.

When we come to consider the local causes of sterility in the male, the history is of considerable importance. An old gonorrhoea with orchitis, mumps, epididymitis or subsequent stricture, chronic prostatitis with morning drop, and sexual exhaustion due to excesses, are conditions for interrogation. Premature ejaculation is occasionally a contributing factor. With the physical examination, one should bear in mind hypoplasia of the testicles or penis, undescended testicles, hypospadius, the condition of the prostate, and its secretions obtained by massage and examined microscopically.

The final, and most conclusive evidence, so far as the male is concerned, is had only by the examination of fresh condom specimens of semen. The men are instructed to collect such a specimen at least a week after the last sexual activity, and present it for examination as soon as possible, usually not more than hour and a half after collection. If the condom is securely tied, and the end with the sperm submerged in warm water (not over 101F.) in a pint Mason jar, the tied end draped over the edge of the jar and the lid firmly applied, the specimen will usually be in excellent condition. The condom is cut, and the semen drained into a small beaker warmed not above body temperature. Several drops are then thinly spread on a warmed glass slide and at once examined microscopically without cover slip, both by low and high power.

Hunner and Wharton[12] found azoospermia or necrospermia in 20 per cent of a series of 526 sterile matings, and others have placed such findings as high as 50 per cent.

The normal specimen will teem with very actively motile spermatozoa. If many spermatozoa are present, but they are inactive or but feebly active, errors in technique are possibly the cause. Otherwise the sperm are inherently defective and of low vitality. A fair estimate of their vitality may be had by observing the duration and degree of motility. The sperm's vitality is influenced by the character of the secretions of the accessory glands, as well as by constitutional factors.[6] Prostatitis and vesiculitis may, however, be present to quite a marked degree without materially affecting the fertility of some men. Any material decrease in the numbers of spermatozoa is of much significance, and frequently no sperm can be found in the ejaculations of men who consider themselves quite normal.

If non-motile sperm are found with their tails curled up, they were probably dead when ejaculated; if their tails are straight, they have died subsequently.[1] Few abnormal cells are motile, and many have no tails.

The high power study of the semen is important. Abnormal sperm forms are often seen from men with lowered fertility. The nucleus may be atrophic or bar-shaped, and the heads of the spermatozoa may have a variety of forms. The presence of pus and tenacious mucus from inflammatory exudates of the seminal tract, in which the sperm become entangled, all suggest factors for the infertility.

It is now quite obvious from what has already been said, that the thorough study of a case of sterility involves many problems, is time consuming, and demands great discrimination in the most careful analysis of a large number of factors. Such efforts will be well rewarded, particularly if they lead to the overcoming of the difficulty, as there is not a more grateful class of patients.

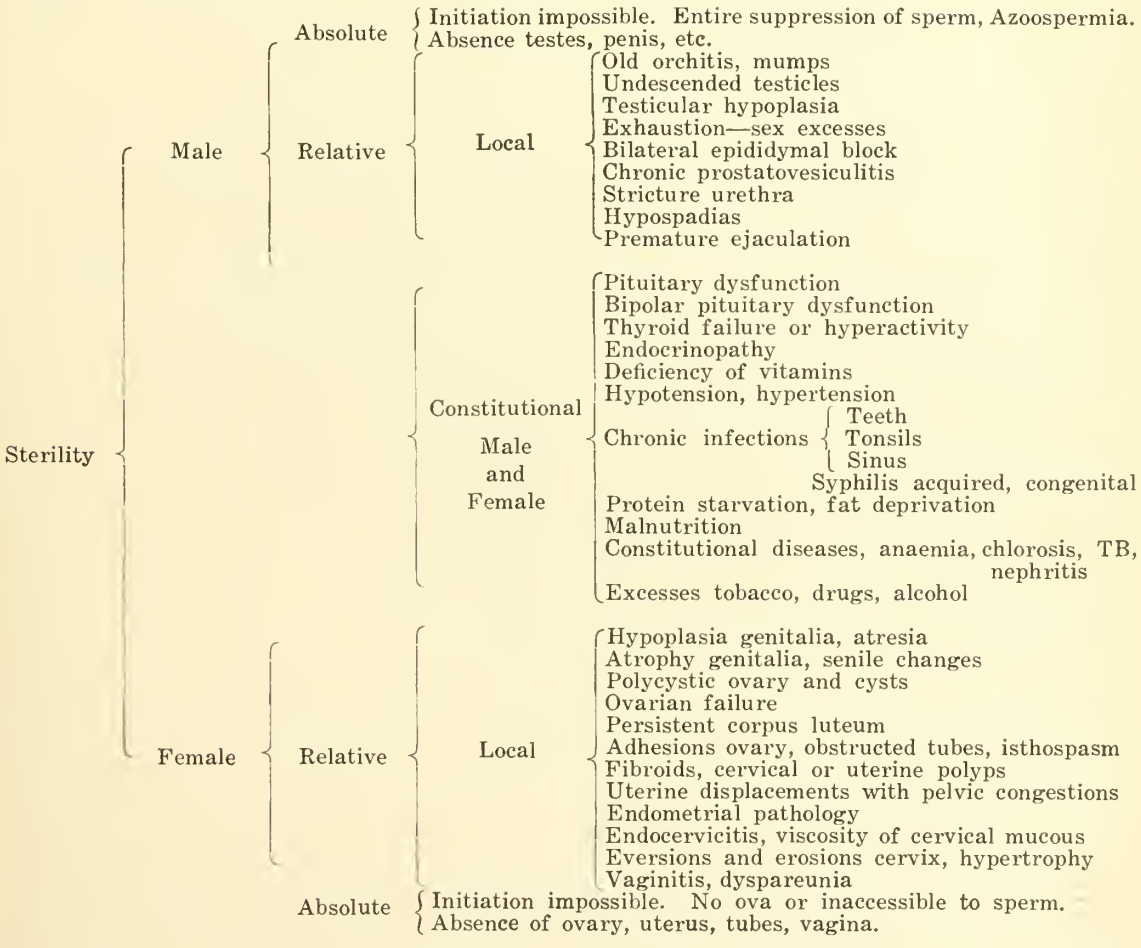
It is wise at the first meeting with these patients, to go into considerable detail and explain some of the more important facts, advising them that the thorough investigation of their case will take time, and the complete cooperation of their

husband and themselves. This investigation should always be inaugurated by taking a very detailed personal history of the woman. Her family history, history of adolescence and all intercurrent diseases, onset of puberty and her secondary sex characteristics, and especially of her menstrual, marital and puerperal record and sexual life. A very complete physical examination should follow, noting the general character of body development, weight, blood pressure, condition of the heart, lungs, and reflexes, any possible source of chronic infection, and look particularly for any evidence of endocrine defect or dysfunction. The external genitalia including the breasts should be carefully examined. Any evidence of infection of Skene's ducts or Bartholin's glands noted, as these would suggest a possible cause higher in the tract for the sterility. Developmental or congenital anatomical defects should be noted. The condition of the perineum and cervix recorded. Particular attention should be given the cervix. Eversions, erosions, lacerations and evidences of endocervicitis with a thick muco-purulent discharge plugging the external os, are of great significance. Bimanual examination will reveal the size, position, and condition of the uterus and ovaries, and usually the presence of any tumors or inflammatory masses.

Having progressed so far with the wife at the first examination, the husband is then advised to come in, bringing a condom specimen. He is subjected to a similar general physical examination, and the condom specimen examined. Particular inquiry should be made relative to former genital infections and their sequellae, and the condition of his external genitalia, prostate and seminal vesicles noted.

The laboratory work which is important, may be made on both husband and wife at the same time, and should include at least a red and white count, hemoglobin estimation, and a Wassermann test. The urine of both patries should be examined, and if at all indicated, a metabolism test may be made on either or both patients.

With the information gained through the investigation so far, the man's position is pretty well understood, and if any etiological factors



have been discovered, treatment of both may be instituted along the lines indicated.

A Rubin test is often advisable, and if gas does not pass freely through the tubes, a lipiodol injection of them is often enlightening.

The treatment of both husband and wife may first be directed towards improving their general physical condition, by such measures as are necessary to eliminate any possible constitutional factors. Next, the local treatment of any pathology, especially of the reproductive organs, may be carried on expectantly, and this refers particularly to unfavorable inflammatory conditions of the cervix and vagina, and to the correction of posterior positions of the uterus by the use of pessaries. At this time, attention should be given any correctable local conditions in the male, and especially of the prostate and seminal vesicles.

Unless frankly indicated in the beginning, surgical interference should be postponed until all expectant means of treatment have been exhausted. The surgical treatment of fibroids by myomectomy gives good results in selected cases. The removal of cervical and uterine polyps, and the repair of chronically infected cervices which have resisted all other treatment, is indicated. Trachelorrhaphy is far preferable to amputation of the cervix, as the latter more frequently continues the sterility, or is followed by abortion if pregnancy does subsequently occur. The surgical correction of uncomplicated posterior positions of the uterus is but rarely indicated, and the attempt to remove tubal obstruction, the result of old inflammatory processes which are not giving symptoms, is almost never justified. The same applies to the freeing of adherent ovaries, puncture of their follicular cysts, or decapsulation, as the results do not justify the means. We have found that thorough dilatation of the cervix, more often without curettage, in small infantile anteflexed uteri, and the wearing of a Carsten stem pessary for three to five months, is followed by good results in selected cases.

To summarize this discussion on sterility we can state that:

1. The husband is alone at fault in one-third to one-half of all cases.

2. Both husband and wife are partly at fault in a large percentage of cases. The threshold of fertility is the product of the fertility of the man and woman.

3. No corrective measures are justified for the wife until the husband is shown to be fertile by the examination of condom specimens or the Huhner test.

4. Constitutional factors play an important part in the production of sterility in both sexes.

5. Cervicitis with its accompanying obstructive mucous is a very important curable cause in women.

6. Tubal insufflation and lipiodal injections are of great help in diagnosing tubal obstruction, often unsuspected.

7. All surgical treatment of the woman, unless clearly indicated, should be deferred until all tentative means have failed.

The attempt to relieve tubal obstruction by surgical means is rarely justified.

The accompanying chart may help bear in mind some of the more common factors of etiological importance in sterility.

1510 KEITH BLDG.

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Parts of the Body Most Susceptible to Injury

Parts of the human body which are more susceptible to injury in industrial accidents are tabulated according to susceptibility in a recent report issued by the Division of Safety and Hygiene, State Department of Industrial Relations, based on the accident experience of Ohio industry during the year 1390.

Figures compiled by statisticians of the division reveal that of the 212,750 industrial accident claims filed with the State Industrial Commission in 1930, 52,743 were for injuries to fingers; 40,632 for injuries to eyes; 26,662 for injuries to the trunk; 20,191 to arms; 20,018 to legs; 17,807 to hands; 13,959 to head and face; 13,379 to feet, and 7359 to toes.

Segregated as to the nature of the injury, the claims show 779 traumatic amputations; 289 asphyxiations; 13,552 burns and scalds; 41,616 crushes and bruised; 255 concussions of the brain; 74,135 cuts and lacerations; 10 drownings; 14,075 ractures; 18,832 puncture wounds; 26,367 strains and sprains; 1026 dislocations, and 21,814 unclassified minor injuries.

An analysis of the 14,075 fractures discloses that 2537 were breaks of vertebrae, sternum, ribs, sacrum and pelvis; 1075 of the skull, nose, jaw and teeth; 2099 of the bones of the arm; 533 of the bones of the hand; 2462 of the fingers; 1587 of the legs; 1409 of the feet, and 2373 of the toes.

Encephalography In Cases of Increased Intra-Cranial Pressure

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ENCEPHALOGRAPHY is an invaluable diagnostic procedure which until very recently has been used far too infrequently in the diagnosis of cerebral conditions. By the term encephalography is meant the spinal subarachnoid insufflation of air for the purpose of roentgenographic examination of the brain, as contrasted with ventriculography in which method the air is introduced directly into the lateral ventricles through trephine openings in the skull.

My experience with encephalography in cases of increased intracranial pressure would seem to indicate that the reluctance with which most neurological surgeons in the past resorted to this method was not entirely justified. During the past year in the Cleveland Clinic 24 encephalograms have been performed in the case of 19 patients in whom the spinal fluid pressures varied from 260 to 850 millimeters of water. Very few untoward symptoms have resulted from the procedure; as a matter of fact, it has been found that patients with brain tumor usually do not have as severe an immediate reaction to a spinal insufflation as do patients in whom other cerebral conditions are present.*

Encephalography should be resorted to in the diagnosis of cerebral conditions only after a careful history of the patient has been secured and a painstaking examination has been made. However, our experience would seem to indicate that in a very considerable number of cases in which a craniotomy is indicated an encephalogram should be made prior to operation. Few general surgeons will operate upon a kidney without a pyelogram having been made or upon a stomach without an *X*-ray examination of the gastro-intestinal tract. On the other hand, many patients with brain tumor have been subjected to an exploratory craniotomy with resultant negative findings, when a cerebral pneumogram would have more adequately localized the lesion. With the present refinements in technic, encephalography may be said to be comparatively safe, when the serious nature of the conditions which indicate its use is considered. Furthermore, by this procedure in many instances gross alterations in the cerebral structure may be diagnosed which can only be guessed at by any other method of examination, not excluding necropsy.

*Read before the Section on Nervous and Mental Diseases, Ohio State Medical Association, at the 85th Annual Meeting, Toledo, May 12-13, 1931.

*This lessened immediate reaction to encephalography in cases of brain tumor is probably due to the fact that as the cerebral sulci are obliterated by increased pressure, little or no air gains access to the sulci. Apparently it is the subarachnoid cortical air which in most cases causes the subjective complaints.

The technic of encephalography is very simple and therefore its application is much wider than that of ventriculography. At the Cleveland Clinic the procedure of encephalography is as follows: The patient is given a hypodermic of one grain of codeine and 1/150 grain of scopolamine one hour before the time set for operation. A preliminary spinal fluid pressure reading is made with the patient in the horizontal position after which he is placed in the encephalogram chair which is mounted on wheels. If the patient is cooperative, local anesthesia is used, but if a general anesthetic is indicated, avertin is preferred. The spinal puncture needle, after being introduced into the lumbar spinal canal with the patient in the sitting position is connected with two two-way stopcock and a ten c.c. syringe which are placed end to end. A spinal manometer is connected to the side-arm of one stopcock, the side-arm of the other stopcock being used for the ejection of fluid from the syringe and for the aspiration of air. An initial pressure reading is then made with the patient in the sitting position following which five or ten c.c. of air is injected before any fluid is withdrawn. The fluid is withdrawn in five c.c. amounts and air is substituted in similar amounts until no more fluid can be obtained. The pressure reading is followed closely and is not allowed to fall below the original reading when the patient was in the horizontal position. If the pressure falls too rapidly more air is injected. If less than sixty c.c. of fluid is obtained and the patient complains of suboccipital pain, an obstructive hydrocephalus should be suspected and the operator should hold himself in readiness to perform a ventricular tap in case of respiratory embarrassment.

During the insufflation of air, the patient's head is gently manipulated forward and backward and from side to side in order to insure a satisfactory emptying of the lateral ventricles. When the operation has been completed, roentgenograms are made with the patient still sitting in the encephalogram chair. If a view of the descending horns of the lateral ventricles is desired, further films should be made with the patient in the horizontal lateral position. This position is necessary in order to empty the descending horns which are dependent and therefore contain fluid when the patient is in the erect posture.

If the patient presents definite evidence of increased intracranial pressure the surgeon should be prepared to operate as soon as the films are available, the reason for this being that the fluid tends to re-accumulate more rapidly after it has been once withdrawn. Thus if the pressure was

Case No.	Age and Sex	History	Positive Findings	Eye Examination	Skull X-ray	Spinal Pressure Horizontal Position
1. 225924	25 yrs. Male	Generalized headache for 5 months. Diplopia 5 weeks. Unsteadiness and dizziness 1 month.	Negative	O.D. — 3 D. O.S. — 3 D. Visual acuity O.U. — 6/6. Fields full.	Convolutional atrophy with atrophy of dorsum sellae.	650 mm.
2. 234680	22 yrs. Female	Occasional headache and dizziness for 12 months. Weakness of right arm and leg with bilateral tinnitus for 6 months. Occasional vomiting for 3 months. Constant headache for three weeks.	Sluggish corneal reflexes. Deviation of tongue to left. Mild right hemiparesis with hyperreflexia. Bilateral Babinski, more marked on the right.	O.D. — 1 + D. O.S. — 1 + D. Visual acuity O.D. — 6/6 O.S. — 6/6. Fields show a slight contraction of the left superior quadrant in both eyes.	Dilated vessel grooves in left frontal region.	315 mm.
3. 232621	39 yrs. Female	Headache for 7-8 years. Occasional convulsions for 1 year. Failing vision for 6 months. Vomiting and vertigo.	Mental torpor and irritability. Non-functioning left 8th nerve, both cochlear and vestibular. Bilateral Babinski.	O.D. — 2 D. O.S. — 2 D. Advanced secondary atrophy. Complete blindness.	Erosion of posterior clinoids.	470 mm. 10 c.c. Removed 190 mm.
4. 230060	30 yrs. Female	Headaches for 3-4 years. Vomiting and failing vision for 2 weeks.	Obesity. Pupils react sluggishly to light. Left 3rd and 6th nerve weakness. Occasional rotary nystagmus.	O.D. — 6 D. O.S. — 4 D. Secondary optic atrophy. O.U. — counts fingers.	Negative	450 mm.
5. 232232	45 yrs. Male	Generalized headache for 3 months. Stupor for 1 week.	Nystagmus, bilateral Babinski. Lower left facial palsy. Questionabla left hemiparesis. Stupor.	O.D. — 2 D O.S. — 2 D.	Negative	100 c.c. 50% glucose intravenously 400 mm.
6. 233329	40 yrs. Mala	Occasional right Jacksonian motor and sensory attacks with transient hemiparesis. Duration 5 months. Headache and vomiting for 1 month.	Negative	O.D. — 1 D. O.S. — 1 D. Visual acuity O.U. 6/5. Fields full.	Negative, calcified pineal not displaced.	270 mm.
7. 234050	13 yrs. Mala	Occasional headache and vomiting for 2 years. More frequent during past 3 months. Drowsiness and enlargement of head 4 months. Failing vision and diplopia 3 months. Staggering gait 1 month. Blindness for past week.	Sluggish mentality. Rather large head. Blindness, nystagmus. Absent corneal reflexes. Positive Romberg. Ataxia. Hyperactive patallars. Bilateral Rabinski. Cracked pot sound on percussion of head.	O.D. — 4½ D. O.S. — 2½ D. Blind.	Marked separation of sutures.	550 mm.
8. 231215	35 yrs. Male	Generalized headache, increasing in severity for past month. Completely irrational for past 48 hours.	B.P. 130/80. Temperature 101. Pulse 70. R. 20. Dehydrated. Stupor alternating with delirium. Stiff neck, posittva Kernig and bilateral ankle clonus.	O.U. No choking of optic discs.	Negativa	700 mm. Struggling 10 c.c. removed 200 mm.
9. 227448	18 yrs. Mala	Lack of physical and sexual development. Headache for past month.	Physical and sexual davelopment of about 10 years.	O.U. Early choking. Visual acuity O.U. — 6/10. Fields show bitemporal inferior quadrant loss for green.	Intrasellar calcification. Sella normal.	510 mm.
10. 226915	19 yrs. Femala	Obesity with increasing mental sluggishness for 5 years. Delayed and irregular menses with onset at 18 years.	Mental sluggishness, obesity with scanty pubic hair.	O.U. — Secondary optic atrophy Visual acuity. O.U. 6/7.5. Fields contracted.	Pronounced convolutional atrophy.	260 mm.
11. 226710	20 yrs. Femala	Occasional headache for 2 years. Constant headache for 2 months with vomiting, failing vision and mild ataxia.	Mild right hemiparesis with ataxia. No nystagmus.	O.D. — 3 D. O.S. — 3+D. Visual acuity O.D. 6/7.5. O.S. 6/10. Fields full.	Negativa	450 mm.
12. 193065	37 yrs. Male	Headache for 5½ years. Bilateral tinnitus for 3 years. Vomiting and falling vision for 1 year.	Nystagmus. Absent corneal reflexes. Lowar right facial paresis. Mild bilateral nerve deafness. Positive Romberg. Pharyngeal and palatal reflexes absent.	O.D. — 4 D. S.D. Visual acuity O.D. 6/7.5. O.S. 6/10. Fields show a concentric contraction.	Negativa	310 mm.
13. 225002	27 yrs. Mala	Severe attack of quinsy 5 months ago. Occasional left Jacksonian attacks with bilateral tinnitus 2½ months.	Slight exaggeration of left patellar reflex. Complete deafness in left ear. Moderate nerva deafness in right. Vestibular responses absent on left.	O.D. — 2 D. O.S. — 1 D. Fields show a questionabla right homonymous cutting.	Negativa	290 mm.
14. 233183	18 yrs. Female	Operation for cervical adenitis 9 months ago. Left parietal headacha for 3½ months. Failing vision and diplopia for 2 weeks.	Operative scar right cervical region. Mild internal strabismus. Right ptosis congenital. Positive Romberg. Tenderness in left parietooccipital region.	O.D. — S.D. O.S. — 4 D. Visual acuity O.D. 6/60. O.S. 6/30. Fields full.	Negativa	2/15/30 700 mm. 2/24/30 850 mm. 4/2/30 850 mm.
15. 232646	16 yrs. Mala	Pansinusitis with septicemia 9 weeks previously. Right sided headache and left hemiparesis for 6 weeks.	Tenderness in right frontotemporal region. Left hemiplegia.	O.D. — 3 D. O.S. — 2 D. Vision well preserved. Questionable left homonymous hemianopsia.	Slight separation of sutures. Small area of osteomyalitis right frontotemporal.	410 mm. 15 c.c. removed 160 mm.
16. 160860	25 yrs. Male	Paroxysmal excruciating headaches for 6 years. Failing vision for 2 months.	Negative	O.D. — 8 D. O.S. — 6 D. Numerous hemorrhages. Visual acuity O.D. 4/60. O.S. 1/60.	Negativa	550 mm. 15 c.c. removed 180 mm.
17. 228417	37 yrs. Male	General weakness. Protrusion of eyes and deafness in left ear for past 4 months.	Generalized adenopathies. Very marked exophthalmos of left eye. Moderata exophthalmos of right eye.	O.D. — 1+D. O.S. — 1+D. Visual acuity O.U. 5/5. Fields full.	Negativa	450 mm. 13 c.c. removed 225 mm.
18. 232398	42 yrs. Female	Headache increasing in frequency for past 8 months. Dizziness, diplopia and failing memory.	B.P. 130/70. Mild mental confusion. Left pupil larger than right. Babinski right.	O.D. — 1 D. O.S. — 1 D. Visual acuity O.D. 6/12. O.S. 6/10. Fields show right homonymous cutting.	Negative	310 mm.
19. 229980	23 yrs. Male	Mild cranial trauma 14 months ago. Headache, vomiting and dizziness for 7 weeks. Loss of 38 pounds in weight. Failing vision.	Emaciated. Bilateral loss of sense of smell.	O.D. — 1 D. O.S. — 1 D. Fields full. Visual acuity O.U. 6/6.	Negativa	360 mm.

ENCEPHALOGRAM (Sitting Position)

Pressure	Pressure	Removed	Injected		Findings	Operation	Remarks
?	?	80 c.c.	?	Local	No subarachnoid air. The anterior horns of the lateral ventricles are displaced to the right.	Left frontotemporal craniotomy with complete removal of frontotemporal meningioma.	Encephalogram performed in this case following introduction of a cannula into right ventricle.
515 mm.	440 mm.	74 c.c.	82 c.c.	Avertin	No subarachnoid air. Air in posterior horns, none anterior.	Left frontal craniotomy with complete removal of midline chondroma arising from dura and sagittal sinus on left side.	A postoperative encephalogram showed dilated ventricles in about normal position.
440 mm.	380 mm.	195 c.c.	205 c.c.	Local	No subarachnoid air. Uniform dilatation of lateral and third ventricles. Fourth ventricle not visualized.	Suboccipital craniectomy with complete removal of left acoustic tumor.	The history in this case was unreliable and the patient uncooperative in the neurological examination. Clinical diagnosis confirmed by encephalogram.
520 mm.	?	27 c.c.	27 c.c.	Local	No subarachnoid air. Lateral ventricles displaced to left. Right ventricle compressed.	Large right temporal decompression.	Blood and spinal fluid. Wassermann four plus. Colloidal Gold 1111210000. Three cells. Diagnosis—right frontotemporal tumor or gumma.
680 mm.	300 mm.	109 c.c.	118 c.c.	Local	Small amount of subarachnoid air over left hemisphere. None over the right. Left ventricle displaced to the left. Right ventricle not visualized.	Craniotomy with partial removal of right temporal lobe glioma. Decompression.	
490 mm.	200 mm.	107 c.c.	115 c.c.	Local	No subarachnoid air. Slight displacement of ventricles to right. Roof of left ventricle depressed. Dilated third ventricle.	Left frontoparietal craniotomy with partial removal of glioma in left prerolandic area at vertex.	
410 mm. following intravenous 50% glucose	350 mm.	220 c.c.	230 c.c.	Avertin	Enormous obstructive hydrocephalus with obliteration of third ventricle. Body of right ventricle pushed upwards and filling defect of body of right ventricle. No shift of midline structures. Some cortical air present.	Right frontoparietal craniotomy with evacuation of large gliomatous cyst and removal of large solid glioma which compressed the third ventricle.	Three weeks prior to encephalography an attempted ventricular tap disclosed a gliomatous cyst in the right parietal region containing 150 c.c. Ventriculogram and cystogram at this time showed the cyst with an obstructive hydrocephalus apparently due to compression of the third ventricle by a solid tumor. Death from pneumonia 2 weeks postoperative.
475 mm.	390 mm.	96 c.c.	90 c.c.	Avertin	No subarachnoid air. Left ventricle dilated and right very much compressed. Both displaced very markedly to left.	No operation	Sudden death 12 hours after encephalogram due to respiratory paralysis. Necropsy disclosed encephalomalacia of the entire right cerebral hemisphere.
660 mm.	450 mm.	42 c.c.	55 c.c.	Avertin	No subarachnoid air. Lateral ventricles greatly dilated as shown by the position of a small bubble of air in each. No air in third ventricle. Fourth ventricle and aqueduct visualized.	Right frontal craniotomy with complete removal of large suprasellar cyst.	Patient died 6 hours postoperative. In this case death was ascribed to operative trauma to the structure in the Interpeduncular region. The pituitary stalk and tuber cinereum were lacerated during the removal of the cyst apsule.
?	?	60 c.c.	60 c.c.	Local	Air between cerebral hemispheres and beneath tentorium. No air in ventricles.	Suboccipital craniectomy with attempt to relieve obstruction of aqueduct.	Encephalogram diagnosis of obstructive hydrocephalus verified by ventriculogram. 375 c.c. removed from ventricles. Patient died 48 hours after operation. Autopsy showed a congenital obstruction of aqueduct of Sylvius.
700 + mm	220 mm.	45 c.c.	45 c.c.	Local	Air obstructed at the foramen magnum.	Suboccipital craniectomy with evacuation of right cerebellar gliomatous cyst.	Encephalogram diagnosis obstructive hydrocephalus. Verified by ventriculogram.
600 mm.	?	55 c.c.	55 c.c.	Local	Air blocked at the foramen magnum.	Suboccipital craniectomy disclosed chronic arachnitis.	Respirations ceased during administration of anesthetic for craniectomy. Reinstituted by ventricular tap.
700 mm.	200 mm.	110 c.c.	100 c.c.	Local	Decreased amount of subarachnoid air. Ventricles displaced to left. Roof of right ventricle depressed.	Drainage of brain abscess of right vertex behind motor area. Streptococcic.	Encephalogram showed abscess to be situated opsetrior to previous exploration.
?	?	2/15/30 110 c.c. 2/24/30 110 c.c. 4/2/30 110 c.c.	80 c.c. 90 c.c. 80 c.c.	Local Avertin Avertin	2/15/30—Very little subarachnoid air. Ventricles displaced to rt. Compression of left posterior horn. Rt. ventricle larger than left. 2/4/30—Little change in picture 4/2/30—Further displacement to the right.	2/11/30—Drainage of extradural abscess. 4/7/30—Parietal craniectomy with evacuation of very large extradural tub. abscess.	Culture of pus sterile. Spinal pressure remained high in spite of apparently adequate drainage. Encephalograms disclosed no evidence of abscess elsewhere. Complete recovery following radical evacuation of large amount of caseous material.
700 mm.	?	92 c.c.	75 c.c.	Avertin	Fourth ventricle contained air but there was none above this point.	Drainage of right frontotemporal staphylococcic abscess 4-5 ounces.	Previous operation disclosed a small extradural abscess in frontal region. Enceph. performed because of suspected multiple abscesses. Films unsatisfactory.
750 mm.	270 mm.	195 c.c.	185 c.c.	Avertin	Very pronounced increase in subarachnoid air. Very mild ventricular dilatation.	Right subtemporal decompression.	No recurrence of headaches. Pressure entirely relieved. Diagnosis—external hydrocephalus of unknown etiology.
590 mm.	200 mm.	146 c.c.	125 c.c.	Local	Ventricles normal. Left ventricle incompletely emptied. Marked increase in subarachnoid air.	Right subtemporal decompression.	Patient died 2½ months after operation with generalized lymphoid hyperplasia.
625 mm.	240 mm.	74 c.c.	67 c.c.	Local	No subarachnoid air. Ventricular system normal.	Left subtemporal decompression.	Spinal fluid was definitely bloody. Blood and spinal fluid Wassermann negative. Diagnosis—spontaneous subarachnoid hemorrhage.
550 mm.	?	120 c.c.	120 c.c.	Local	Subarachnoid air normal. Very mild ventricular dilatation. Otherwise normal.	Right subtemporal decompression with evacuation of large serous subdural effusion.	As the intracranial pressure was not relieved following the first operation, two subsequent encephalograms were performed which disclosed no evidence of tumor. A left subtemporal decompression was also performed. At present the intracranial pressure is entirely relieved and the patient is well on the road to recovery.

high before the procedure, alarming symptoms may develop eight or twelve hours later unless a tumor is removed or a decompression provided. In the series of cases here reported no unfavorable postoperative symptoms were noted which could be traced to the previous air insufflation. One patient, who was not operated upon, died twelve hours after encephalography had been performed. Similar accidents, however, have followed ventriculography, ventricular estimation or even a simple spinal puncture. This patient, by the way, was critically ill before the procedure, and at necropsy was found to have an extensive encephalomalacia involving one entire hemisphere.

If an obstructive hydrocephalus is present, or if the brain is markedly distorted by a rapidly expanding hemispheric lesion, the ventricles may fail to empty properly. However, complete emptying of the ventricles has been observed in the case of obstructive hydrocephalus due to posterior fossa as well as to suprasellar tumors.

Failure to obtain satisfactory films by encephalography is probably not of more frequent occurrence than by ventriculography if the proper technic is observed. The preliminary injection of five or ten c.c. of air prior to the withdrawal of the fluid helps to insure satisfactory films and has not caused annoying symptoms. After the films have been obtained, the surgeon should correlate the roentgenographic findings with the clinical findings and should plan his operation accordingly.

The preliminary intravenous administration of concentrated glucose, or a ventricular tap, does not appear to be necessary either from the standpoint of safety to the patient or for the insuring of satisfactory films.

In analyzing the data in the accompanying table, it will be found that of sixteen cases of suspected brain tumor the lesion was correctly localized by encephalography in twelve instances, and in the remaining four cases the presence of a brain tumor was definitely excluded. Of the cases localized by encephalography, cerebral hemispheric tumors were present in seven, a suprasellar cyst was present in one, and four were cases of posterior fossa lesions. In two of the latter four cases a subsequent ventriculogram was performed in order to substantiate the findings from the encephalogram. In four cases a suspected brain tumor was definitely excluded by the encephalogram findings, the final diagnoses in these four instances being as follows: Spontaneous subarachnoid hemorrhage in one case, external hydrocephalus in two cases, and subdural effusion in one case. Of three cases of brain abscess, the lesion was correctly localized in two and in the third case the lateral ventricles failed to fill.

Of the nineteen cases here reported, fourteen patients are living at the present time and in the case of nine of these fourteen the cure is apparently complete. Patient No. 17 died of a systemic condition four months after a right subtemporal decompression had been done. Patient number 10 died seven days after encephalography, 48 hours after a ventriculogram had been made and a suboccipital craniectomy performed which failed to relieve a congenital stricture of the adequate of Sylvius. Patient No. 7 died of pneumonia two weeks after the evacuation of a large gliomatous cyst containing 150 c.c. and the removal of a large solid glioma which was pressing upon and obstructing the third ventricle. Patient No. 9 with with symptoms of a vasomotor collapse six hours after the complete extirpation of a large suprasellar cyst. Patient No. 8 died of respiratory failure twelve hours after encephalography, and necropsy in this case disclosed extensive encephalomalacia.

In some of the above cases an encephalogram was not necessary for the localization of the tumor; however, the films gave added proof that a tumor was present, so that if it were not found on the cortex, the operator could feel more justified in making a subcortical search.

SUMMARY

It appears that encephalography is a safe procedure in cases of increased intracranial pressure provided the surgeon is prepared to operate immediately after the findings from the encephalogram have been obtained. The autopsy table has shown that no one is infallible in cerebral localization and the neurological surgeon who spurns such laboratory aids as cerebral pneumography must pay the price in a higher percentage of negative explorations.

CLEVELAND CLINIC.

Dr. Paul B. Brooks, a member of the New York State Board of Medical Examiners, makes the following suggestions in the *New York State Medical Journal* to future candidates taking the state medical examinations:

1. Be sure you understand the questions. Devote more time to thinking, less to writing.
2. Answer questions fully but also briefly and concisely.
3. Don't throw in information not called for.
4. Don't attempt to conceal ignorance in a mass of useless verbiage. It can't be done.
5. Use simple language. Don't try to make an impression by using big words.
6. Remember that an examiner with a large number of papers to rate does not want to waste time digging around in an effort to find out whether the candidate really knows the answers.
7. The purpose of licensing examinations is not to determine whether or not the candidate knows the answers to certain quetsions, but rather to ascertain whether or not he is capable of practicing medicine intelligently.

Mental Hygiene as a Public Health Measure

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THE earliest human beings probably were the hosts of organisms that produced in them disease and death. The gathering of isolated groups into large tribes facilitated the distribution of these organisms and increased the chances for contagion. With the development of urban life still larger groups of men were more closely associated under unsanitary conditions that provided a fertile field for the spread of epidemics, and plague and pestilence took their toll. Even in ancient times the need for preventive measures was evident to the more enlightened, and organized public health work was carried on; not as we understand it today but in accordance with the ideas of disease prevalent at the time. The usual resort was to charms and incantations to propitiate the good or evil spirits, and only in quite recent times have these means been supplanted by measures directed against infective material itself.

The recognition of the efficacy of vaccination in the prevention of smallpox gave a great impetus to the search for specific causes of disease and by the discoveries of Pasteur preventive medicine was placed on a scientific basis and well-directed public health measures were made possible.

And what of mental hygiene? We have no data from which we may determine the prevalence of mental and nervous disorders in primitive men but it is probable that even among our early human ancestors there were some who showed marked deviation from the accepted standards of mental and emotional expression. We know that in the remote historical era, madness was not uncommon and emotional instability is frequently described. Considered an evidence of divine displeasure or a domination by evil spirits, preventive measures were wholly religious. And we may assume that religion among more primitive peoples has been an important factor in the prevention of some forms of nervous disorder. Worry, apprehension and remorse will not dig deeply into the emotions of an individual when he can place the blame for misfortune and failure upon divine will or truly believe that the evils he suffers in life are but the preparation for future joys. But education leads to self analysis, and today we are inclined to place the blame for our failures upon faults within ourselves and not throw it upon the shoulders of divinity.

We are, however, still in the age of mysticism in much that pertains to mental hygiene. Neither the microscope nor the laboratory can explain to us the functioning of a diseased mind or show us the causes of emotional imbalance. The syphilitic neuroses and psychoses are the only ones for which we have a scientifically determined etiology, and for our attack upon the remaining great problems in the field of mental hygiene we have only empirical measures. It is perhaps because of our lack of an established foundation upon which to conduct a clearly outlined plan of mental hygiene that until recently so little attention has been given to this subject in public health programs. It is also probably true that only those dealing with nervous and mental disorders have any conception of the magnitude of the problem with which mental hygiene deals.

The mentally ill are a more serious drain upon a community than the physically ill. There are more hospital beds required for the care of the insane and mental defectives than for all medical and surgical cases combined. In the United States alone there are at the present time more than 400,000 inmates of institutions devoted to the care of the mentally afflicted, with an annual admission rate of more than 100,000. Perhaps Dr. Haven Emerson's statement of the expectancy of mental disorders will emphasize their importance. He says: "Of the young people in our schools and colleges about one million will become inmates of institutions for the insane." The human misery and economic loss resulting from insanity alone are sufficient to win for mental hygiene a prominent place in public health programs, and they constitute but a small part of the problem with which mental hygiene has to deal. The number of individuals who are social liabilities because of mental deficiency, delinquency, criminality or dependency, is well above a million in the United States alone. It is not the unimportance of the mental hygiene problem that has prevented its assuming first place in public health measures, but a lack of an assured method of attack.

In 1908 the first mental hygiene society was organized, with the object of improving methods of handling the insane and providing for the after care of those who had so far recovered as to again take part in the world's work. Its scope was soon extended so that it embraced the study of all forms of mental dysfunction with the hope of preventing their development or finding a cure. A great deal of earnest work has been done during the past few years, but unfortunately there were no scientific checks upon psychological speculations and as a result we have a multitude of theories and very few facts. Sensational claims have been made as to the social betterment to be attained through the employment of various methods of treatment advocated, but, ex-

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cept in the field of child study and training, we have little evidence of accomplishment.

In order to correct conditions that may cause mental disturbances we must first know what they are. The first great task for mental hygiene is a comprehensive unbiased study of the factors that may be instrumental in causing the emotional and intellectual changes that constitute the neuroses and psychoses. Unsupported assertion leads us no where. There is no gain to psychiatry in the mere assertion that all mental dysfunction is dependent upon hereditary faults, nor on the other hand that environment alone is the determining factor. We may assume that the Mendelian law applies to brain cells as well as to those of bone or muscle and that therefore we do inherit mental characteristics. Some individuals develop a psychosis or a neurosis when environmental conditions have been of the best, yet others fail to develop them under the worst conditions, and others remain normal until they are subjected to various degrees of emotional strain. The type of nervous system we inherit will determine our resistance to mental and nervous disorders in large part, but we may assume that under certain conditions a brain normally resistant may give way in an adverse environment. The environmental factors we may hope to modify by education and, perhaps some day, through eugenics, we may control, in part at least, hereditary influences when we have more knowledge of them.

At the present time we hear a great deal about the influence of mental conflicts in causing insanity or nervous diseases but here again there is room for much study. At least very frequently these conflicts are themselves symptoms of mental disorder, evidence of the individual's inability to adjust himself to influences that the normal person meets without injury. Do repressions produce a neurosis, or is the morbid reaction of the patient to a customary repression in itself an evidence of disease? We cannot say that our young people of today with their comparative freedom from repressions are less subject to nervous disorders than were those of the super-repressed Victorian era. Repression is civilization. Men cannot live together in groups unless they suppress natural tendencies and instincts that if given free play might be offensive or detrimental to their associates. Is it not true that much of the repression apparently at the root of mental disorders is built up by the individual himself because of his own morbid trend of thought?

There are many questions to be answered before we can approach the problems of mental hygiene with any hope of solving them. It is perhaps an inner conviction of the inadequacy of our knowledge of the etiology of mental disease that has switched us away from a study of prevention for the adult and directed our attention to the problems of children, in which there is more hope of accomplishment. There are, however, at least two adult fields in which public health measures may result in great good. Because of public apathy the care of the insane has not reecived the attention it needs. Of the general public only the families of the insane have a direct interest in improving the conditions under which the inmates of our insane hospitals live, and they and the medical officers of the institutions constitute too small a group to exert much influence upon those who determine the amount of care the insane should receive. If public health bodies would interest themselves in this matter they could through publicity and political pressure bring about very great improvement in the care of the insane. Over-crowding, such as exists in our hospitals for the insane would not be tolerated in institutions for the physically ill, nor would it be in insane institutions if the public could be made to realize how serious the conditions are.

Another field for public health activity is that of vocational guidance. As civilization advances life becomes more complex and the stress and strain upon the mass of people becomes greater. As a result a constantly increasing proportion of our people are unable to master the difficulties that confront them and succumb to insanity or severe neuroses. At the best the strain of modern living makes a strenuous assault upon our nervous resources, and if the struggle for existence or to keep our place in the social order is made under conditions which make success difficult or impossible, the probability of a mental break is greatly increased. This is a public health problem that is already receiving attention, but one that demands a much wider application. We cannot hope that life will become less strenuous but we may hope to better adjust man to its increasing demands and thus contribute to his happiness and perhaps to his mental security.

In the fields of dependency and crime we are still in darkness or at best in the twilight zone. There have been many ill-considered statements made of what could be done in crime prevention, but as yet we have had no evidence of accomplishment. A much clearer knowledge of dependency and crime must be attained before public health measures can be applied to them. We cannot apply the Spartan method for eliminating the unfit and only rarely do we use it in disposing of our worst criminals. Even sterilization of the mental defectives, the chronic insane and the habitual criminal is impracticable because of adverse opinion. Any other measures than these have not seemed to have produced results.

In the field of child study a great deal of conscientious effort has been expended by earnest and able men in the study of the mental reactions of children and much has been accomplished in correcting errors of management which result in

unhappiness and mental unrest. One of the weaknesses of child study is the tendency to interpret the child's reactions in terms of adult psychology and to ascribe to him conflicts and emotions that could only arise from more mature reasoning and experience. Even the morbid reactions of young children result from surface stimulation and not from reasoning or deep-seated conflicts. The young child is keenly alive to new impressions but is not analytical of them. Their importance is measured by the immediate sensations they produce. Until judgment and reason develop, his reactions are almost reflex. It is important therefore that the stimuli he receives are such as will produce healthful reactions. Repeated reactions become habits, and persistent unhealthful stimuli may develop habit patterns that will later be very detrimental to the well-being of the child.

The training of young children will never be undertaken by public health organizations, but more and more attention is being given to the training of parents. The advancement made in the physical care of children is almost startling but it is doubtful whether we have made great progress in mental care. The training of the average child is not dictated by wisdom and logic but rather by the emotions of the parents, which are but little influenced by reason. Progress is being made, however, and the rational training of parents in child guidance will occupy an increasingly important place in public health programs. To be effective this training must be in expert hands and be free of fads and the influence of cults. We must not think that we can mould a child into any pattern we select. There seem to be predetermined lines upon which an individual will develop and these must be considered in our plans for the child guidance. Forced into a situation he does not understand or cannot master, the child evades, or if that is impossible, rebels. It is often this resistance to being forced into an impossible situation that produces morbid reactions in children.

We cannot be content with mere guidance in the management of children. Social living is an artificial condition, and we are forced to mould and repress in order that a child may be fitted into this artificial environment. By training we seek to direct the child in paths that will lead him to security and happiness, to build up in him habits that will make adjustment to his environment easier.

In early life this training is wholly in the hands of parents or those assuming the place of parents. Health organizations touch it only through parent education. A little later, however, a great deal of child training passes into the hands of the public.

The distance from the home to the school cannot be measured in yards or miles. For the child it is passage into a new world. From the solicitude and protection of the home he passes into a sphere of rivalry and conflict. There is no fixed place assigned him in this new environment and the position he will occupy must be determined by his own efforts. If he has received healthful training in the home his adjustments may be readily made, but if he has had little group experience or has been the object of too much solicitude and over-indulgence in his home, his adaptation to this new environment is difficult. If he is a normal child he will, however, adjust himself to group habits, but not until his emotions have received some severe shocks. He then must fit himself to the discipline and the educational requirements of the class room.

Our schools are largely machines designed to stamp upon the minds of the average child the rudiments of an educatiton. While the need for individual study and teaching is recognized, the school room groups are too large to permit of other than mass handling. This is inevitable in any system of public instruction and mental hygiene can do no more than insist upon a curriculum adapted to the mass of pupils and eliminate from the group those who deviate to a marked degree to either side of the normal.

Every child should have a psychometric test before or soon after he enters school and a suitable course of study provided for those who are either subnormal or of superior intelligence. Children with so little intelligence as to rank in the feeble-minded or low grade moron group are easily recognized, are withdrawn from school and given what instruction they can assimilate in their homes or placed in institutions for the feeble-minded. But the high grade morons and the borderline group are not so easily recognized, and may be considered quite normal until suitable tests show their mental inaptitude. Their inability to learn is ascribed to indifference, or stubbornness, or lack of application, and they are goaded and punished until the school becomes for them a place of torment. Often, too, when a child is known to be dull, efforts are made to force into him learning which he is incapable of acquiring.

There are still many good people who believe that if only they exert sufficient effort the dull pupil must learn the things his brighter fellows have mastered. Recognition of the child's mental limitations would save him from much uncalled for punishment and prevent wasted effort on the part of the instructor. It would also greatly reduce misconduct in children, for many of the problems of school room discipline arise from an attempt to force children to do things that are impossible for them. Truancy we should expect, but lying and stealing, destructiveness, assaults and sex offenses are also frequent reactions to improper management. A study of a child's capabilities and a suitable course of study then provided for him would not only lessen the nervous strain in the class room, but would reduce

school delinquency and greatly add to the comfort and happiness of both teacher and pupil.

The abnormally bright child may also become delinquent unless provided with a course of study suitable to his intelligence. Truancy, disobedience, impertinence and often graver delinquencies result from boredom he feels because of lack of mental stimulus. Provision for the physical health and comfort of school children has been made in our large schools and physical examinations are a matter of routine. This in itself is a mental hygiene measures for we all know that illness may be an important factor in the production of emotional imbalance and behavior problems. But if our efforts to discover physical ailments and prevent the spread of contagion were supplemented by a careful search for mental irritations and measures taken to eliminate them, the result to the child and to the school would, I am sure, be very much greater. Some form of child guidance organization should be connected with every school, and as much attention given to sanitation in the mental field as in the physical.

Much also can be done during school life toward vocational guidance, the education of the child being directed in lines in which he shows particular aptitude, making adult adjustments much easier. Much nervous unrest and mental suffering has resulted from efforts to make a potential ditch digger into a priest, or a lawyer, or a physician.

If his home life is sensibly organized, if his school adjustments are carefully regulated, and, above all, if he is fortunate in having parents or guardians who are progressive and wise, we need not fear that the normally constituted child will find adolescent adjustment difficult. Even from unhealthful childhood environment the normal mind seems to emerge without serious permanent injury. But of this we cannot be sure and all sane measures for improving conditions under which a child develops are worthy of an advanced place among public health measures.

Nowhere in the field of mental hygiene is there more need for reason and restraint than in that of child guidance. A great deal of foolishness has been written about the training of children, and claims of benefits to be derived are even less restrained than the patent medicine advertisements of older days. Such methods are not only unfortunate but dangerous. The flighty plans of some teachers of child guidance have caused the whole uplift movement to lose the confidence of a great mass of thinking men and women. On the other hand the blind credulity of a great group of women in anything pertaining to psychology leads them into emotional paths that often make their management of children harmful.

We have not yet sufficient knowledge of child or adult psychology to lay down any fast rules other than those dictated by common sense. To substitute the theoretical plans of some psychologists for the practical ones of the home would be disastrous. The technique in many homes may be greatly improved, but only by one who knows.

It is probable that we shall see no miracles result from mental hygiene. No one can promise that the measures we are now employing will bring about a very noticeable decrease in the incidence of mental and nervous diseases. Only the passage of years will determine the preventive value of the work now being done, but there is sufficient promise to stimulate us to ever increasing effort, with the hope that we may lessen the misery and economic loss by at least a partial control of the incidence of mental and nervous disorders, and the knowledge that we are bringing comfort and happiness to children who suffer from the ignorance or uncontrolled emotion of their adult guardians.

1110 EUCLID AVENUE.

NEW BOOKS

Courts and Doctors, by Lloyd Paul Stryker, New York City, until recently and for many years, general counsel for the Medical Society of the State of New York; a volume of 236 pages containing authoritative information and discussion on medico-legal questions, based on the author's long experience in handling legal problems affecting the medical profession; MacMillan Company, 60 Fifth Avenue, New York City; Price $2.00.

A Doctor of the 1870's and 80's, by William Allen Pusey, M.D., former president of the American Medical Association; an account of a country doctor, without resort to fiction and uncolored by romance; Charles C. Thomas, publisher, 990 East Monroe Street, Springfield, Illinois; price $3.00.

Primer on Fractures, Second Edition, prepared by the Cooperative Committee on Fractures; for use by both students and practitioners; material covering the points demonstrated in the Scientific Exhibit at the Philadelphia A.M.A. meeting, in addition to that used at the four previous annual sessions, and legends written by members of the Cooperative committee on Fractures—Drs. Allison, Darrach and Speed. American Medical Association Press, 535 North Dearborn Street, Chicago, Ill. Price $1.00.

Health Protection for the Preschool Child. A National Survey of the Use of Preventive Medical and Dental Service for Children Under Six. Report to the Section on Medical Service. White House Conference on Child Health and Protection. George Truman, Dr. P. H. Palmer, chairman, Subcommittee on Statistics. Mahew Derryberry. Research Assistant. Philip Van Ingen,, M.D. chairman, Committee on Medical Care for Children. The Century Company, New York.

Conquering Arthritis. By H. M. Margolis, M.D. The MacMillen Company, New York.

Metrazol as a Stimulant During Surgical Anesthesia

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ONE of the greatest boons given to mankind was surgical anesthesia. Nevertheless it is still fraught with danger despite precautions. This is shown perhaps best by those anesthetic deaths classed as unavoidable. In such cases we are very often forced to face the unknown, the patient may die suddenly and even on autopsy reveal no cause of death. Fortunately such occurrences are not common and generally death from surgical anesthesia can be avoided. A careful examination of the patient should always precede the induction of anesthesia. This will determine the proper choice of the anesthetic and, if necessary, what prophylactic treatment should be given.

When any of the danger signals of anesthesia, among them irregular breathing, rapid pulse, marked fall of blood pressure, and dilatation of the pupils appear, one must be prepared to act promptly. An efficient cardiac and respiratory stimulant in such crisis often spells the difference between recovery and death of the patient. No anesthetist, in fact, unless he or she were irresponsibly reckless, would dream of giving an anesthetic to a patient unless proper stimulants were at hand for any emergency which might arise. Sometimes a need for stimulating the patient's cardiac or respiratory centres, or both, arises unexpectedly. At other times anesthesia has to be given in emergency cases where complications are expected to arise during the course of the narcosis. The question is, which is the best stimulant to give. The action of camphor is often unreliable and usually of too short a duration. Caffeine may stimulate as expected but again in toxic patients it may increase the critical depression caused by the narcotic action of the anesthetic instead of giving the desired stimulation. Strychnine is also unreliable in patients in shock. Ephedrine and adrenalin are not entirely satisfactory and present some dangers in their use. Digitalis is too slow in its action. All of these are in daily use and must not be condemned except as far as known disadvantages in their use exist.

Because of these difficulties the anesthetist must welcome a stimulant which will affect both the respiratory system and the whole cardiovascular system, and which will take hold promptly and regularly and will still continue to exert its action for some time. We believe such a stimulant has been found in metrazol (pentamethylentetrazol). It certainly gives clinical results. Its action on the patient can be seen almost immediately after subcutaneous injection. The respirations become regular and deeper—the pulse slower and the blood pressure rises. Usually cyanotic conditions are promptly relieved. Also the reaction is not over in a few minutes as with camphor, but lasts a half hour and usually longer. Several times we felt an injection of metrazol was all that saved the patient from death.

To illustrate the action of metrazol more concretely, we give below a short abstract of a few typical cases. The anesthetics used were nitrous oxide and ether, the amount of ether varying from 2 to 8 ounces. The McKesson gas-oxygen machine, or slow-drop ether method usually was employed. The condition of most of the patients before operation was fair, though in some cases indications pointed to the probability of having to sustain the heart during the anesthesia. The cases varied from ectopic gestation with extreme anemia to ruptured appendix—general peritonitis to empyema of the gall bladder in a case of pernicious anaemia as described below. Preoperatively the patients all received 1/6 to 1/4 gr. of morphine half an hour before the surgical procedure.

CASE REPORTS

Case I.—P. W., white male, aged 27. Appendectomy for gangrenous appendix. During the operation the pulse rose rapidly to 112 and was weak and thready. One ampule of metrazol was given subcutaneously as the patient was leaving the operating table. Within fifteen minutes the pulse fell to 80 and became fuller. The respirations became noticeably easier and deeper. The patient made an uneventful recovery.

Case II.—P. H., white, female, aged 45. Laparotomy for large infected fibromyoma with general peritonitis and free pus in the abdomen. The patient went into collapse during the operation. The pulse was weak, thready and rose to a rate estimated between 140 to 170 a minute. One ampule of metrazol was given which immediately caused an improvement in the condition of the patient but it was still so critical that ten minutes later a second ampule of the same drug was given. Thereupon, in a few minutes, the pulse improved very much, the rate fell to 124, the heart sounds became louder and clearer and the respirations likewise became slower, regular, and much deeper. While this patient died the next day, we felt that the metrazol alone prevented her exitus on the operating table.

Case III.—E. H., highly nervous, white, female, aged 54. Cholecystectomy for gall stones. During the operation the pulse became extremely rapid and weak and the respirations irregular. One ampule of metrazol was given with the result that the pulse and respirations picked up immediately and remained good throughout the further progress. At the conclusion of the operation the pulse was only between 70 and 80. The patient made an uneventful recovery.

Case IV.—J. A., white, female, aged 79. This patient developed broncho-pneumonia. Metrazol sustained the heart well and made respiration much easier. The metrazol was given as indicated

Anesthetist at the Deaconess Hospital,

and after each injection of one ampule of metrazol decided improvement could be seen. The patient recovered completely in two weeks.

Case V.—F. L., white, female, aged 32. Caesarian section for placenta praevia. During the operation the patient went into collapse. The radial pulse was not perceptible. Two ampules of metrazol were given within ten minutes and also saline infusions. A prompt reaction occurred. The pulse became strong and regular, the respirations practically normal. An uneventful recovery followed.

Case VI.—E. L., obese white female, weighing 200 pounds, aged 35. Curettage and trachelectomy and appendectomy. The pulse during the operation rose to between 140 and 160. The respirations were 30 to 35. After one ampule of metrazol the pulse and respirations fell markedly. The pulse rate did not go above 88 during the rest of the operation, and an uneventful recovery followed.

Case VII.—E. C., white, female, aged 27. Very much under weight. Right salpingo-oophorectomy, appendectomy. Within five minutes after the induction of the gas oxygen anesthesia the pulse became irregular and weak. One ampule of metrazol was given and the patient placed in the Trendelenburg position. Within five minutes both pulse and respirations were practically normal.

Case VIII.—N. T., white, female, aged 42. Operation for empyema of the gall bladder. The blood count in this patient, suffering from pernicious anemia, was 1,455,000 red cells. During the operation the pulse became weak and rose to 140 and 150. One ampule of metrazol within a few minutes produced an effective reduction of the rate and marked increased amplitude of the pulse, also an improvement of the respiration.

Case IX.—R. B., white, male, aged 36. Cholecystectomy, appendectomy, freeing of adhesions between the gall bladder and a duodenal ulcer. Due to the manipulations required, the respiration and pulse became impaired. The pulse rose to 120 and 130. The respirations were at the same time very rapid and shallow. One ampule of metrazol was given and within ten minutes the pulse fell to 90, never going above 96 during or following the operation. The respirations became deeper, slower and more regular. An uneventful recovery followed.

These few clinical experiences may serve as examples of the value of metrazol in our hands. We feel that in these cardiovascular emergencies we obtained better results and with greater certainty of effect with metrazol than we had achieved previously with other stimulants used under similar conditions.

CONCLUSION

Metrazol seems to be the stimulant of choice for complications arising during surgical anesthesia because:

1. It affects beneficially both the respiratory and the whole cardiovascular system.
2. It acts promptly, and its action is sustained for a sufficiently long time.
3. It may be given repeatedly at short intervals.

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Personal Preventive Medicine

V. C. ROWLAND, M.D., Cleveland, Ohio

Note—The following paper on the above subject, prepared by Dr. V. C. Rowland, chairman of the special Committee on Periodic Health Examinations of the Ohio State Medical Association, incorporates some of the ideas and suggestions which have been in the minds of this committee and through which the committee desires to repeat and re-emphasize the importance of the growing movement of periodic health examinations by physicians in their private practice as one of the important phases of popular preventive medicine.

The personnel of the Periodic Health Examination Committee, under whose direction the paper is published, is as follows:

V. C. Rowland, Chairman	Cleveland
Jonathan Forman	Columbus
Beatrice T. Hagen	Zanesville
R. R. Hendershott	Tiffin
C. I. Stephen	Ansonia

Progress in the Periodic Health Examination movement is unmistakable during the last two years. It is in the direction of a broader conception of the movement to include the whole of personal preventive medicine. The historical perspective is necessary to see it as a logical development following upon the achievements of public health measures which are instituted comparatively promptly after the birth of bacteriology. Public sanitation revolutionized the relative incidence of disease. Only after its limitations were recognized by "irreducible minimums" and increasing degenerative and nervous disease, did it become apparent that an "era" of personal cooperation of the individual was necessary for the next great advance in preventive medicine.

The rapid rise of specialism and its brilliant advances in the last generation undoubtedly have, to some extent, obscured the field of general practice and personal preventive medicine. It appears that preventive health service through a system of periodic health examinations provides a new opportunity to the people at large to reestablish their connections with a family medical adviser and mentor in matters of health. It also identifies the movement as part of preventive medicine, which undoubtedly will loom larger in the future.

CURRENT PROFESSIONAL ACTIVITIES

In Detroit an extraordinary program of preventive work has been carried out by Dr. H. F. Vaughan, Commissioner of Health, with the hearty cooperation of the medical profession. A three year agreement was made with the Medical Society that all treatment was to be given by private practitioners but on the condition that if

the plan failed, the responsibility would revert to the Health Department. Their first work was the popularization of diphtheria immunization. Dr. Vaughan's plan was to have all injections given by the private practitioner, none in public clinics. After a campaign of publicity in the newspapers, by posters, and personal interviews by the public health nurses, who made 250,000 visits in four months, it was announced that for people who could not go regularly to their private physicians, special hours would be set aside by the same physicians during which toxin antitoxin injections would be given for a nominal sum or free if necessary. If nothing was paid by the patient the Health Department paid the private doctor a nominal fee for the service.

The result was that all parties concerned were pleased. About 80 per cent of the school and 70 per cent of the pre-school children of Detroit were immunized. Private practitioners received $120,000 ($145 per cooperating physician) from the Health Department in addition to $100,000 in private fees for work that never would have been done if the campaign had not been launched. The children were protected and the Health Department credited with one of the most outstanding and progressive pieces of constructive work in the United States. At the same time money was actually saved for the city as calculated on the cost of the care of diphtheria cases and antitoxin for the previous year. In the same period the number of smallpox vaccinations greatly increased without any special effort. It was also learned that the personal interview is the most effective means of getting the average individual to his physician for preventive health service. Public Health nurses were successful in this in about 75 per cent of cases. To the various publicity measures there was only about a 20 per cent response. These facts again indicate the field and the educational opportunities of the Public Health personnel and the advantages from their own standpoint of cooperation with the private physician.

The Detroit experience is direct proof that preventive medicine pays—pays everybody concerned. And yet there was great "sales resistance" to the plan in the beginning. Remarkable as the outcome was, financially and otherwise, it should be pointed out that it made use of only one preventive procedure. With all the possibilities that come up in the periodic health examination and with only about 2 per cent of the population sick and 98 per cent apparently well, we ought soon to get the newer viewpoint of the practice of preventive medicine. As has been repeatedly pointed out, it is a matter of viewpoint, preventive mindedness, rather than any special knowledge. What special information and technique are necessary may be readily acquired if really desired. In fact in Detroit as a result of the educational effect of the campaign, 150 physicians have taken up a three year course in communicable diseases and preventive medicine offered by the Health Department. It is being taught that in the end the practice of preventive medicine is more profitable as well as more satisfying and productive of results in the preservation of the health of the community than curative medicine alone.

The Greater New York Committee on Health Examinations also carried out a campaign since our last summary of the status of the movement two years ago. The New York Academy of Medicine has given enthusiastic support to the work and is prepared to lend all of the facilities of organized medicine to the furthering of this form of preventive medicine. Economically, sickness and premature death cause heavy monetary losses to the commonwealth. Ultimately these costs fall upon society at large. Their prevention is important whether by public or personal health measures. In fact at present by far the greater loss of life as well as economic loss is due to causes not amenable to public health control. The medical profession which has taken on the responsibility of the health of the individual obviously has an obligation in the direction and control of the whole of personal preventive medicine. Prevention is the essence of modern medicine, but must be personal as well as public in order to really apply our available knowledge.

The two month's campaign in New York was formally opened by a proclamation by Mayor Walker. The various publicity methods were published in the *Journal* of the American Medical Association and are now widely known. To the profession sample record cards were distributed and later sold in quantity at cost. A book on the subject "Outlines of Preventive Medicine" by thirty authorities was sold at the reduced price of $2.50 and 750 physicians and 250 dentists purchased copies. A Questionnaire from the physicians after the campaign showed "increased interest among patients in Health Examinations" in 68 per cent but actual request for such examinations in only 38 per cent. To the question "In your opinion was the recent campaign valuable?" 75 per cent of replies were "yes" and to the question "Would the campaign have been more effective if continued over a longer period of time?" 85 per cent were "yes".

From these data the idea of a continuous educational program emerged instead of a short intensive and somewhat sensational campaign. Accordingly "*The Five Year Program of Activities*" was developed. The campaign had demonstrated the competence of the medical profession to promote aggressively a public health measure of the first magnitude and the receptiveness of the press and the public to messages from the profession and the willingness of the public to cooperate. Actual results, however, in establishing health examinations as an everyday part of medical practice require the slow process of education not

only of the laity but of those physicians who lag in their appreciation of the opportunities of prevention and of the trend of modern medicine.

The projected five year plan in New York places the major emphasis on the physician and is to be carried out through medical schools, post graduate organizations, hospitals, etc., and by Bulletins from the committee. It is so essential that the interest and preparedness of the profession be equal to the demand of the public. "The Health Examiner" has now appeared monthly since May, 1931, presenting the whole matter in attractive form from authoritative sources. It may be obtained at $1.00 a year from the Greater New York Committee at Number 2 East 103rd Street, New York.

Outside of Detroit and New York, activities on Health Examinations are less well organized and more difficult to evaluate. In American Medical Association circles there certainly is increasing reference to the movement. Dr. Dodson of the Bureau of Health and Public Instruction has recently sent out 2000 copies of a questionnaire on the subject to county medical societies. So far a 50 per cent response has been obtained, which is quite good in these days of many questionnaires. Results will be published later. There seems to be in general more interest in the Eastern than in the Western States.

EXTRA-PROFESSIONAL ACTIVITIES

Insurance companies continue to offer free examinations to their policy holders under certain conditions, although they definitely state that they would much prefer to have this preventive work done independently by the practicing physician. The personal relationship between the family doctor and the patient in the periodic health examination is always better than any standardized procedure. About 8 per cent however, of insured individuals have availed themselves of the opportunity of an insurance examination. Although this represents a large group and much educational leavening of the public, it obviously requires more than a casual suggestion for most human beings to concern themselves about conditions which may in the future lead to distress and suffering or even premature death. Foresight is a virtue which needs to be cultivated in all fields of activity. Health and efficiency, however important, are no exceptions. There is great interest, of course, in certain intelligent groups of laymen.

In industry including the railroad systems on the other hand, health examinations are being done in ever increasing numbers. The educational effect of this in time will be enormous. About 67 per cent of all employees of a group of industries (presumable representative of all industry) referred to in the report of the Ohio State Periodic Health Examination Committee two years ago were not only examined when employed but periodically reexamined thereafter.

Round-up campaigns through the schools and for pre-school children have been unsatisfactory in some respects. However, the National Congress of the Parents and Teachers asked the aid of the medical profession and sought to conform to the methods of procedure advised by the American Medical Association. The movement is being developed on a large scale since 50,000 children were reported on in 1929 with treatment by the family physician in 26,000 cases. Obviously it will be increasingly necessary for the private physician to cooperate in this work or to make it unnecessary by developing a thorough periodic health examination system in private practice. Dr. John M. Dodson of the American Medical Association states: "It is inconceivable that any considerable proportion of the members of the American Medical Association can long remain unconvinced of the wisdom of the action already taken by the Association in regard to the matter or can fail to respond cordially to the call for service in this field".

VENEREAL DISEASE

Venereal disease with over 2,000,000 new cases each year in the United States presents a major public health issue in which personal cooperation and prophylaxis are essential. It is quite beyond any public health measure. Education and prophylaxis can be carried out through periodic health examinations as the opportunity arises. Every physician understands the practical difficulties and the weaknesses of human nature in relation to venereal disease. It is an established fact, however, that prophylaxis is effective in a high percentage of cases. If we could reduce the incidence 5 per cent, the saving would be enormous. Any system that would materially reduce the vast amount of venereal disease would in the end be socially justifiable. The conventional attitude today would, however, not permit of public educational propaganda. In fact under some circumstances and at certain ages it would be suggestive and objectionable. The discretion of the mature physician in the individual case is needed and the health examination provides the most suitable occasion. Personal habits naturally and easily come up for discussion. That personal influence and relationship between physician and patient, which we prize so highly in the best forms of medical practice may be developed in proportion to the skill, experience and humanitarian interest of the individual doctor. An impersonal and perfunctory physical examination is not a real health examination. The main opportunity of preserving health would be missed in many cases.

TUMORS

Cancer accounts for about 100,000 deaths in the United States annually. Of these many thousands

are of a type that early diagnosis and treatment would permit of radical cure. Pre-clinical diagnoses through periodic health examinations are essential. Nothing but the voluntary cooperation of the patient and the sympathetic human interest and mental preparedness of the doctor will succeed in making this a matter of routine practice. Pre-cancerous lesions, ulcers, polyps, irritations, leukoplakias, keratoses, pigmented moles, etc., may be removed. By such methods alone, until we have a new discovery in the cause of cancer, can we lower the enormous mortality from malignant disease.

Benign growths often present opportunities in the health examination to prevent serious operations or subsequent illness and premature death. For example, small but growing uterine fibroids in younger women or in older women with menorrhagia in properly selected cases may be treated by *X*-ray. Every surgeon of experience recognizes that hysterectomy for the neglected large fibroid represents a real operative risk.

Benign tumors of the breast and in some other places are always potentially malignant and should be removed.

DIABETES

A million diabetics in the United States bear witness to the great neglect of preventive medicine. The majority of these cases are mild, in older obese individuals with no definite ill health. They lack, however, in normal vigor and efficiency and as is well known are subject to infections, carbuncles, septicemia, gangrene, hypertension, cardiovascular and other complications.

The dietetic control of this group of cases as well as of obesity in general, with its increased mortality rate presents an enormous preventive opportunity. Periodic Health Examinations simply represent an organized movement to meet the situation.

TUBERCULOSIS

Prevention in tuberculosis is steadily proving its case in reducing the annual mortality from about 200 to 76 per 100,000 in the last fifteen years. Early diagnosis is the great need for cure. What physician can deny the opportunity in the health examination. Unrecognized even advanced tuberculosis in medical students has been a stigma on our medical faculties in the past. Student health services have not been particularly popular, but have developed in spite of criticism, partly because of the great lack of private preventive health service or periodic health examinations.

The newest approach to tuberculosis prevention is by a systematic study of "contacts". These cases, usually children, remain symptom free for years. Physical signs are inconspicuous or absent at times even when the disease has progressed to apical cavity. *X*-ray is an indispensable aid in the follow-up of these cases. Nutrition and weight are now known (Rathburn and Chadwick) to bear no constant relation to childhood tuberculosis that is demonstrable by *X*-ray.

Accordingly at least one Ohio organization, the Cleveland Tuberculosis Bureau, has established a "Contact Clinic" with the high ideal of filing an annual *X*-ray film of all contact children over twelve years of age and of supplementing this by a program of tuberculin testing in the younger group. This is more elaborate than anything ever before attempted. Their aim and hope is that in the years to come tuberculosis may be classed with diphtheria and typhoid fever as a cause of death.

This is modern medicine in relation to tuberculosis and the periodic health examiner must recognize it. He can use the *X*-ray in following the children of tuberculous parents. If the cost is prohibitive and contact clinic service is available, it may be used without surrendering control of the case at all. The properly conducted Contact Clinic needs the practitioner of medicine, and should and will respect his viewpoint. In the end public and personal preventive medicine are identical. Their common aim is health, the greatest asset of the nation.

OTHER PREVENTIVE OPPORTUNITIES

Without reference to other specific diseases, the State Committee on Health Examinations wishes to call attention to the importance of noting general states and factors in disease and of following up their implications in relation to their age group, family background and potential diseases—such as gall bladder disease, diabetes, and hypertension with obesity; gastro-intestinal ulceration in nervous dyspeptic types of individuals with grossly faulty dietary habits; mental breakdowns in psychopathic types and untreated syphilitics; arthritis with neglected focal infection and chronic malnutrition; occupational diseases from industrial poisons, fatigue and other health hazards.

A broad humanized approach to the possibilities of preventive health service will be much more fruitful than any meticulous tabulation of detailed physical findings. Purposeful examination will then be carried out by all available methods.

CONCLUSION

The Committee feels very strongly that the trend of medical practice is toward the preventive viewpoint and that recognition of this trend and adjustment to it by the profession is imperative. It is by meeting the newer conditions and obligations, that we hold the high regard of the public. Technical skill is not enough. We must have the progressive spirit and a dynamic leadership in matters of individual and public health. It will be the most effective way to avoid occasion for encroachments by the state upon private practice and at the same time will give the greatest human service by advancing the application of medical science to modern living. Every physician in Ohio has the opportunity through the Periodic Health Examination movement of participating in a really great but unostentatious crusade for a higher standard of health and happiness.

The President's Page

A Personal Communication to the Membership from

D. C. Houser, M.D., Urbana, Ohio

If you have not paid your 1932 annual dues in your County Medical Society which includes your dues in the Ohio State Medical Association, you should do so at your earliest convenicnce since a physician's continuous good standing in medical organization is contingent on the payment of his dues on or before January 1 of each calendar year; and the period of delinquency runs from the first of the year to the day and date on which dues are received at the State Association Headquarters. All dues, of course, are payable through the Secretary-Treasurers of the Academies or County Medical Societies, and not direct to the State Association.

Perhaps, you carry various kinds of insurance—life insurance for the benefit of your family in case of your death; insurance to cover losses in the damage or theft of property; automobile damage and liability insurance; insurance to cover sickness and accident, and medical protective insurance.

It seems to me in these days of social, economic and governmental unrest, that the most important "assurance" any physician can possibly have is *membership* in his County Medical Society and the Ohio State Medical Association.

While membership in medical organization is an *assurance* of a physician's good standing in his community, before the public, the law and the profession, it, furthermore, is the strongest protection for all physicians against exploitation, excessive socialization, destruction of professional relations and annoying and malicious attacks of various kinds.

Activities of the State Association have gone a long way toward preventing unwarranted suits and threats of suits; in minimizing attempts by disgruntled patients to profit at the expense of members of the profession, and thwarting the activities of racketeers who constantly are attempting to stimulate such suits and threats. The medical defense plan, of course, is not indemnity insurance but is of added value and protection even to those members who carry such insurance.

Of course, a physician's eligibility to any and all the benefits of medical organization depends in the first place upon continuous membership in his County Medical Society and the State Association, for a physician in arrears in his dues is not in good standing and a physician not in good standing is not entitled to the benefits of membership.

There are many other important and equally as valuable benefits you derive from membership in medical organization. You, no doubt, can enumerate these as well as I can.

In my opinion, no physician can afford to let a single month go by without reading carefully from cover to cover the *Ohio State Medical Journal*, the publication of which is made possible by a portion of the dues of the State Association. The annual per capita dues in the State Association are only $5. *The Journal* alone is worth more than that. Besides the scientific and news departments of *The Journal*, you will find discussed in the news and comment, from time to time, many subjects of vital importance. These subjects cover a wide range, viz:—legal, legislative, social, economic, ethical, all of which are discussed in a very able and constructiive manner.

Allow me to mention our State Association headquarters, in Columbus, where valuable information is kept, and to which you have access, if you are a member of the State Association, as another benefit of great value.

If you have not yet paid your 1932 membership dues you should see the Secretary-Treasurer of your County Medical Society at once.

In closing this month's President's Page, I feel that I should again remind you of the importance of Periodic Health Examinations. In some sections of the state, the doctors realize that the Periodic Health Examination is here to stay and is becoming a very important part of their practice, while in other sections, a great many of the physicians seem rather slow in availing themselves of the splendid opportunity afforded by these examinations. Let me urge you to give this your earnest consideration.

It is the first of February, three months until the Eighty-Sixth Annual Meeting, to be held in Dayton, May 3 and 4. Have you marked those dates on your calendar? If not, do it now, as Dayton is looking for you. You, no doubt, have been more or less dissatisfied, most of the time, the past year and felt that the old world was a poor excuse, so be at the meeting this year, and Dayton, the great airplane city, will take you up in the sky and the earth will again look good to you.

Federal Income Tax Returns Must Be Made Before March 15, ⁂ Regulations, Procedure and Ruling Applying to Physicians Are Here Analyzed

Blanks for making federal income tax returns for the calendar year 1931 have been mailed by Collectors of Internal Revenue to all taxpayers of record and must be filed with them on or before March 15, 1932.

Returns must be made in accordance with and pursuant to the Revenue Act of 1928 and Regulations issued under authority thereof.

In other words, the blanks are identical to those furnished for returns for the calendar year 1930, filed on or before March 15, 1931, and the same procedure in filling them out should be followed.

Physicians making returns on income for the year 1931 should compute their tax the same as last year on the following basis:

First $4000 of income subject to normal tax should be taxed at 1½ per cent; the next $4000 at 3 per cent, and the remainder at 5 per cent.

Personal exemptions should be listed as follows: $3500 if married and living with wife, or if head of a family; $1500 if single and not a head of a family; $400 credit for each dependent under 18 years of age.

Surtax and tax on corporation incomes should be figured on the same basis as in returns made in 1931.

Physicians in making their returns should not be confused by newspaper reports from Washington relative to a proposed revision of individual income tax rates and exemptions during the present session of Congress with a retroactive provision making the new tax rates—if any—applicable to income during the calendar year 1931.

Despite the agitation for an increase in the income tax rates and a decrease in the personal exemptions, and the publication of the recommendations of Secretary of the Treasury Mellon for a sweeping revision of the present federal tax laws, the United States Commissioner of Internal Revenue early in January ordered all Collectors of Internal Revenue to mail to all taxpayers of record, blanks which had been prepared in conformity with the Revenue Act of 1928 and which are identical with those distributed last year for the return of income data for the calendar year 1930.

Up to the time the February issue of *The Journal* went to press, Congress had taken no action toward a revision of the federal income tax law. Just what action may be taken is highly problematical at this time.

Whatever measures may be enacted revising the present Revenue Act and changing the rates and exemptions on federal income taxes will have no effect whatsoever on the procedure which must be followed now by physicians who are required to file returns under the provisions of the present law. *You should proceed to make out your return in the same manner as last year.*

Should there be an increase in the rates and a decrease in the personal exemptions, with a provision for making the new rates and exemptions retroactive for the calendar year 1931, necessary adjustments on all returns will no doubt be made in the offices of the Collectors of Internal Revenue and the taxpayer subsequently informed concerning the higher tax he will be required to pay.

However, physicians who are exempted from filing a return under the income tax law as it now stands should thoroughly familiarize themselves with any changes Congress may make at a later date.

Some physicians who are not required to file a return under the provisions of the Revenue Act of 1928, now in force, might become liable for making a return should Congress decrease the statutory exemptions.

Physicians whose status would be changed from non-taxpayer to taxpayer by a revision of the Revenue Act should, in case proposed revisions are made by Congress, get in touch with the Collector of Internal Revenue in their respective districts to obtain the necessary blanks for filing a return and receive information as to how to proceed.

Failure to receive a blank does not relieve a physician of the responsibility to file a return on or before March 15, 1932. If blanks are not received by a physician who is required by law to file a return, he should apply at the internal revenue office of the district in which he resides. These districts, with the name and address of collectors, are appended to this article.

Following is a detailed analysis of the procedure physicians should follow in filling out the blanks which they have, or should have, received for the 1931 returns:

THOSE WHO MUST FILE RETURNS

Every physician whose net income for 1931 was $1500 or more, if single, and $3500 or more, if married, must file an income tax return with the Collector of Internal Revenue of his district *on or before March 15, 1932.* He also must file a return if his gross income was $5000 or over, irrespective of marital status and irrespective of *net* income.

All physicians and other professional men are required to use Form 1040 in submitting their

return, regardless of the amount of net income.

Data for income tax returns should be arranged on separate sheets under the following classifications: Gross Income, Exemptions, Net Income, and Tax Computations.

GROSS INCOME

Gross income includes gains made from professional services, business activities, certain forms of dividends, bad debts charged off in previous years but since collected, bonuses received as compensation, interest, partnership profits, profits from sale or exchange of real estate, rents and royalties, and funds received from other sources.

PERSONAL EXEMPTIONS

If married and living with wife, or head of a family for the entire year, an exemption of $3500 is allowed; if single and not a head of family, an exemption of $1500 is permitted. In case of change of marital or head of family status during calendar year, the personal exemption is prorated over the period of married, head of family or single state. Credit of $400 is permitted for each dependent under 18 years of age, or each physically or mentally handicapped dependent regardless of age. The credit is not allowed in the case of a dependent minor over 18 years of age even if such minor is attending school.

DEDUCTIBLE ITEMS

Office Rentals

If a physician pays rent to another person for office space, he may deduct the amount; if he owns his own home and maintains an office in it, he cannot claim deduction for office rent.

Automobile

The cost of repair and upkeep of an automobile used in professional visits may be deducted. That part of a salary paid to a chauffeur and attributable to time spent in driving his employer on professional calls, may be deducted. Sums spent for taxi hire, car fare, etc., while on professional calls, may be deducted.

Loss on an automobile used in professional business through depreciation may be deducted. The depreciation which should be deducted annually is figured by dividing the cost price of the machine by the number of years of its usefulness.

If a physician has one automobile which is used exclusively in professional business, he may deduct the full depreciation each year. If the machine is used only partly in professional business, the deductible depreciation should be computed on the basis of the amount of time the car is used for professional purposes.

If a physician possesses two cars, each of which is used partly in professional business, the deductible depreciation on each car should be computed on the basis of the amount of time each car is used for professional purposes.

In other words, if an automobile is used only partly for business purposes, depreciation may be deducted only on a proportionate part thereof, the amount of depreciation depending on the amount of time the machine is used in professional business.

Professional Dues

Dues paid to professional associates to which, in the interest of his profession, the physician belongs are exempt and may be deducted. Traveling expenses incurred in attending medical conventions of organizations of which he is a member are deductible from gross income in determining net income derived from practice. Expenses incurred in taking graduate courses have been held *not* to be deductible.

Assistants

Deductions are permitted for the salaries of nurses, laboratory workers, technicians, assistants, stenographers or other clerical workers in offices so long as their duties are connected with professional work. Wages paid maids for services rendered in connection with practice are deductible.

Medicines, Instruments, Supplies

Medicines used in the office to treat patients, medicine dispensed, bandages, laboratory materials and all other supplies necessary to operate the office may be deducted. Upon surgical instruments, one-fifth of purchase price may be deducted annually for five years under depreciation account. All office fixtures, appliances, etc., used in office or laboratory may be depreciated annually, according to the estimated life of their usefulness.

General Office Expense

Cost of telephone, telegrams, etc., used in professional services may be deducted. Expenditures for heat, light, water, etc., are deductible. Office fixtures and furnishings may be depreciated 10 per cent annually. Original cost of medical books may be depreciated 10 per cent annually, since the life of these is usually considered 10 years.

When to Deduct Debts

If the physician's books are kept according to the "Cash Receipts and Disbursement" system, he may not charge off any unpaid debt because he is then only reporting as gross income those accounts which have proved to be good. Bad accounts have not been reported and are therefore, not deductible.

If books are kept on an "Accrual Basis" (where expense is actually incurred and payable even though not yet paid, or income earned although not yet collected) it is permissible to charge off all debts which have been definitely ascertained to be worthless during the fiscal year covered by the report.

In the same way, the physician is permitted to

claim deduction for all other expenses within the scope of his profession, and the amount of his tax is determined on the net income which remains after these items have been deducted.

Taxes and Licenses

Any tax paid upon materials required in professional work are exempt. All license fees which physicians are required to pay are deductible items. This includes the narcotic tax, automobile license, local occupational taxes, taxes on club dues, etc. The Ohio Gasoline Tax is not deductible.

Losses by Fire and Theft

Loss of and damage to a physician's equipment by fire, theft, or other cause, not compensable by insurance or otherwise recoverable, may be computed as a business expense, and is deductible, provided evidence of such loss or damage can be produced. Such loss or damage is deductible, however, only to the extent to which it has not been made good by repair and the cost of the repair claimed as a deduction.

Insurance Premiums

Premiums paid for insurance against professional losses are deductible. This includes insurance against damages for alleged malpractice, against liability for injuries by a physician's automobile while in use for professional purposes, and against loss from theft of professional equipment, and damage to or loss of professional equipment by fire or otherwise.

Legal Expense

Expense incurred in the defense of a suit for alleged malpractice are deductible as business expense. However, expenses incurred in the defense of a criminal action are *not* deductible.

Other Allowable Deductions

All taxes paid upon real or personal property, whether the property is used for business or otherwise and all interest paid upon indebtedness (except interest paid to carry nontaxable securities) are deductible. It is permissible to deduct from gross income contributions when made to charitable, religious, educational and scientific organizations, to an amount not to exceed 15 per cent of the net income, exclusive of such contributions.

ITEMS NOT REPORTABLE AS INCOME

Allowances received under the War Risk Insurance act; bequests; damages received in personal action; dividends on stock of federal reserve banks, land banks and intermediate credit banks; dividends from exempted building and loan associations up to $300; dividends from corporate earning accumulated prior to March 1, 1913; gifts, inheritances, insurance proceeds; state court jury fees, state court receivership fees, life insurance proceeds; and stock dividends and rights, are not reportable as income.

All interest received from obligations of a state or political subdivision thereof; from securities issued under the Farm Loan act; interest on Liberty 3½% Bonds and U. S. Bonds issued prior to September 1, 1917, and interest on the obligations of the possessions of the U. S. need not be included in the computation of gross income.

Interest received on Liberty 4% and 4½% Bonds and certain other U. S. obligations is exempt if the total holdings are not in excess of $5000. All interest received on U. S. Treasury notes must be reported. However, all interest received from these sources which is reportable as income, is subject only to surtax.

NORMAL TAX

As explained previously in this summary, the normal tax rate on 1931 income is 1½% for the first $4000 in excess of exemptions and credits; 3% on the next $4000 in excess of exemptions and credits; and 5% on the balance over and above the first $8000 in excess of exemptions and credits.

Another Different But Important Tax Return

Every member of the State Association should bear in mind that Ohio's new tax law, providing for the classification of personal property for taxation and for a flat rate taxation of intangibles, became effective January 1, 1932.

Returns under the new Ohio law must be filed with the county auditor in duplicate between February 15 and March 31. Failure to receive a proper blank for making the return will not be accepted as an excuse for failure to make a proper return of all taxable property. Blanks for returns are now being printed by the State Tax Commission and will be distributed on or before February 15. Any physician who fails to receive a blank should obtain one from the county auditor of his county as heavy penalties are provided in the law for failure on the part of a person possessiong taxable personal property to make a return.

As pointed out in an article analyzing some of the provisions of the new Ohio personal property tax law, published in the December, 1931, issue of *The Journal*, pages 965-967, the new law is intricate and complicated, so every physician should be extremely careful in making out his return. In case of doubt as to the meaning of any requirements of the new law, competent advice should be obtained.

SURTAX RATES

In addition to the normal tax provided above, a surtax is levied on net incomes of $10,000 and over. The percentages in these follows: $10,000 to $14,000, 1 per cent; $14,000 to $16,000, 2%; $16,000 to $18,000, 3%; $18,000 to $20,000, 4%; and an additional 1% for each $2000 added up to $24,000. After $24,000 each $4000 increase is subject to an additional 1% surtax until $64,000 is reached when there is another change in brackets.

EARNED INCOME

Earned income is taxed at a lower rate than income from sources other than "earned". Earned income may consist of salaries, wages, commissions, professional fees and other amounts received for personal services actually rendered, or an amount not in excess of 20% of the net profits derived from a trade or business in which both personal services and capital are material income producing factors.

A physician may include as "earned" income money paid by patients who were looked after in part by his assistants. In order to do so, however, the patients on whose account the money was paid must have been in fact the patients of the physician-taxpayer and have looked to him as responsible for the services performed. Moreover, the services must have been performed under the physician-taxpayer's supervision.

The prevailing ruling of the Treasury Department relative to "earned income" was interpreted as follows in Mimeograph No. 3802 issued by that Department:

"It was not intended to deny the taxpayer the right to consider the entire amount received as professional fees as earned income if the taxpayer is engaged in a professional occupation, such as a doctor or a lawyer, even though the taxpayer employs assistants who perform part or all of the services, provided the clients or patients are those of the taxpayer and look to the taxpayer as the responsible person in connection with the services performed."

"This mimeograph will also apply to income received as professional fees from a professional partnership, even though the partnership employs assistants who work on a salary basis, provided the clients or patients are those of some active member of the partnership and look to some active member of the partnership as re- with the services performed."

If the business requires only a nominal capital and the income is derived principally from personal services of the taxpayer, as a doctor or lawyer, the entire profits, not exceeding $30,000 may be considered as earned income. The first $5000 of net income constitutes earned income no matter from what source derived. In order that the earned income may be taxed at a lower rate, such income is included with income from other sources and the tax figured thereon. The tax is then figured on the earned net income alone, and 25% of that tax is used as a credit against the tax on the entire net income. This credit is termed an "earned income credit" and in no case may exceed 25% of the normal tax on income from all sources plus 25% of the surtax on the earned net income.

HOW COMPUTATIONS MADE

An example of how computations are made is given here for the information of physicians. Suppose a physician was married during the year 1931, has no dependents, and rents his home and his office. He compiles the following data:

Gross income from professional service	$18,000.00
Depreciation of office fixtures, etc.	500.00
Office help, etc.	2,000.00
Telephone, Heat, etc.	500.00
Occupational tax, licenses, etc.	100.00
Auto cost and depreciation, etc.	1,000.00
Drugs, bandages, etc.	3,000.00
Scientific Journal, etc.	400.00
Railroad fares on professional calls	250.00
Traveling expenses to medical conventions	250.00
Office rent	1,500.00
Miscellaneous expenses	100.00
Total expense	$ 9,600.00
Gross income from other sources:	
Rent from apartment house	10,000.00
Overhead, taxes, etc.	8,000.00
Total Gross Income	$28,000.00
Less deductible items for profesisonal services	9,600.00
Less deductible items incident to apartment building income	8,000.00
Net income, $28,000 less $17,600	$10,400.00
Less personal exemption	$ 3,500.00
Income subject to normal tax	6,900.00
Taxable at 1½%	4,000.00
Taxable at 3%	2,900.00
Normal 1½% tax on $4,000	60.00
Normal 3% tax on $2,900	87.00
Total Normal Tax	$ 147.00
Surtax (1% on net in excess of $10,000)	4.00
Total Normal and Surtax	151.00
Less Earned Income Credit (See Computation)	21.75
Net Tax Liability	$ 129.25

Computation of Earned Income Credit

Total receipts from practice	$18,000.00
Expenses incident to practice	9,600.00
Earned Net Income	8,400.00
Less exemption	3,500.00
Subject to normal tax	4,900.00
Taxable at 1½%	4,000.00
Taxable at 3%	900.00
Normal 1½% tax (on $4,000)	60.00
Normal 3% tax (on $900)	27.00
Total tax on Earned Net Income	87.00
Twenty-five per cent credit (earned net income)	$ 21.75

DISTRICTS AND COLLECTORS

Any physician failing to receive an income tax blank should apply to the Collector of Internal Revenue for his district. These districts, together with the name and address of the Collector, and counties comprising such districts follow:

For the Columbus District (Ohio 11th) Collector of Internal Revenue Newton M. Miller, Postoffice Building, Third and State Sts., Columbus, Ohio; comprising the following counties:

Adams, Athens, Coshocton, Delaware, Fairfield, Franklin, Gallia, Guernsey, Hocking Jackson, Knox, Lawrence, Licking, Madison, Marion, Meigs, Morgan, Morrow, Muskingum, Noble, Perry, Pickaway, Pike, Ross, Scioto, Union, Vinton and Washington.

For the Cleveland District (Ohio 18th) Collector of Internal Revenue C. F. Routzahn, 262 Federal Building, Cleveland, Ohio; comprising the following counties:

Ashland, Ashtabula, Belmont, Carroll, Columbiana, Cuyahoga, Geauga, Harrison, Holmes, Jefferson, Lake, Lorain, Mahoning, Medina, Monroe, Portage, Richland, Stark, Summit, Trumbull, Tuscarawas and Wayne.

For the Cincinnati District (Ohio 1st) Collector of Internal Revenue L. J. Huwe, Custom Building, Cincinnati, Ohio; comprising the following counties:

Brown, Butler, Clarke, Clermont, Clinton, Fayette, Greene, Hamilton, Highland, Miami, Montgomery, Preble and Warren.

For the Toledo District (Ohio 10th) Collector of Internal Revenue Wm. B. Guitteau, Toledo, Ohio; comprising the following counties:

Allen, Auglaize, Champaign, Crawford, Darke, Defiance, Erie, Fulton, Hancock, Hardin, Henry, Huron, Logan, Lucas, Mercer, Ottawa, Paulding, Putnam, Sandusky, Seneca, Shelby, Van Wert, Williams, Wood and Wyandot.

New Sanitary Regulations For Barbers and Hairdressers, and Their Places of Business, Now Effective

Amendments to several sections of the Ohio Sanitary Code, adopted by the Ohio Public Health Council, making more stringent and definite the sanitary regulations governing the practice of barbering, manicuring, hair dressing, cosmetology, and chiropody, and the establishments operated by such artisans, become effective January 1, 1932.

The new regulations have been printed on a card by the State Department of Health which are furnished to health commissioners on request for distribution to operators of establishments governed by the regulations.

One requirement of the new regulations is that the regulations must be posted in a conspicuous place in all establishments coming under their provisions.

Action of the Public Health Council should meet with the approval of leaders of these various trades, especially the barbers and hair dressers, who have contended that a more efficient system of regulating barber shops and beauty parlors should be established in the interest of public health.

At the recent session of the Eighty-Ninth General Assembly, two measures, one sponsored by the organized barbers and the other by the organized hair dressers, were introduced, each providing for the creation of a state licensing board to regulate and supervise the practice of the craft. Both the barbers and the hair dressers argued in support of their bills that they provided ways and means for the enforcement of stringent sanitary regulations for barbering and hair dressing establishments and were primarily public health measures.

The bill sponsored and supported by the organized barbers was enacted by both branches of the General Assembly after heated discussions and much log-rolling, despite the fact that opponents of the bill pointed out that it was monopolistic, that it would create another special licensing board in the state government, and that it was entirely unnecessary from the standpoint of sanitation and public health since under present health laws and the authority vested in the State Department of Health adequate means are provided for additional regulation and supervision of such shops for the protection of the public.

Governor White vetoed the measure and no attempt was made to pass it over his veto. The Chief Executive pointed out in his veto message (published on Page 503, June, 1931, issue of *The Journal*) that "the state, county and city health regulations pertaining to barber shops are ample to cover every reasonable requirement" and that "there is plenary power now given the various health services to enforce the same". Governor White also stated that in his opinion the legislation weakened, if anything, the existing health and sanitary regulation of barber shops and barbers.

Similar arguments of sanitation and health were used by the sponsors of the hair dressers' bill in an effort to have their measure enacted, but the bill never came to a vote, remaining on the Senate calendar at the time of adjournment.

Objections similar to those raised against the barbers' bill were made against this measure.

The action of the Public Health Council in tightening up the sanitary regulations for barber shops, beauty parlors, etc., is in accord with the statutory authority and power given that body "to make and amend sanitary regulations to be of general application throughout the state" and provide uniform health and sanitary regulations which may be enforced by local public health administrators.

It has been pointed out by some observers that the action of the Public Health Council may have a deterrent effect on the reported plans of the organized barber trade and the hair dressers for another attempt at the 1933 session of the General Assembly to have legislation enacted creating special licensing and examining boards to regulate and supervise their crafts. It has been pointed out that although the sanitary code of the state has for years been adequate, if properly enforced, to protect the customers of barber shops, beauty parlors, hair dressing establishments, etc., the code as recently amended provides even more stringent regulations for such establishments and definitely meets all arguments that regulations governing the conduct of such shops are inadequate.

The regulations, as amended by the Public Health Council are as follows:

Regulation 138. [Barbers and barber shops.] Every barber or other person in charge of any barber shop shall keep such barber shop at all times in a clean and sanitary condition.

No person shall act as a barber who has syphilis in the infective stage or any other communicable disease enumerated in this code, or any communicable affection of the skin.

The hands of the barber shall be thoroughly washed with soap and water before serving each customer.

Shaving mugs, brushes and combs shall be thoroughly cleansed and immersed in boiling water before being used on each customer.

There shall be a separate clean towel for each customer. The headrest shall be covered with a clean towel or paper and shall be changed after each customer.

Towels known as "steamers" shall be fresh towels and shall be used only once without relaundering.

No hair cloth or other cloth which is used on more than one person shall be placed directly against the neck of the customer being served, but shall be kept from direct contact by the use of an individual paper neck band or clean towel. The use of any neck band on more than one person is prohibited.

Alum or other material used to stop the flow of blood shall be applied in powdered or liquid form only.

Barbers shall refuse to handle a customer affected with any eruption, or whose skin is broken out, or is inflamed or contains pus unless such customer is provided with a shaving cup, lather brush and razor for his individual use. No barber or other person in charge of a barber shop shall undertake to treat any disease of the skin.

The shaving cup, lather brush, razor and other implements used for a customer affected with any of the above named disorders or conditions shall be made safe immediately after such use by being immersed in boiling water for not less than twenty minutes.

Tweezers used for removing embedded hair shall be immersed in boiling water or be passed through a flame before being used.

Regulation 139. [Manicures, hair dressers and chiropodists.] The utensils and instruments used by manicures, hair dressers and chiropodists in the pursuit of their occupations shall be kept in a clean and sanitary condition. The same regulations shall govern the operations of manicures, hair dressers and chiropodists as are required for barbers and barber shops.

Regulation 140. [Regulations to be posted.] Every barber or other person in charge of any barber shop, hair dressing establishment or beauty parlor, or other place where barbering, manicuring, hair dressing or chiropody is done shall post in a conspicuous place in such establishment a copy of Regulations 138 and 139 of the Ohio Sanitary Code.

State Hospitals and Institutions Receive Emergency Funds

The State Board of Control has released $131,500 in state funds to be used by the State Department of Public Welfare for institutional improvements at the various state institutions.

The items for which the funds will be spent include:

Institution for Feeble-Minded at Columbus, $3500 for an ash conveyor.

Cleveland State Hospital, Hawthornden farm, $20,000 for laundry and kitchen equipment.

Dayton State Hospital, $25,000 for ice plant, storeroom and equipment; $7500 for plumbing renewal, $5000 for rewiring.

Lima State Hospital, $4000 for boiler and engine repairs, $1500 for sluice at reservoir, $2000 for track repairs.

Longview State Hospital, $16,000 for renewal of sewer in main building, $5000 for rewiring.

Massillon State Hospital, $7500 for laundry equipment, $6000 for well and equipment.

Ohio Hospital for Epileptics, $3500 for deep well.

Girls' Industrial School, $3000 for new ammonia compressor; $16,000 for laundry equipment; $1000 for bakery equipment.

Medical and Surgical Licenses Issued to 30 at Mid-Winter Meeting of State Medical Board; Other Board Activities

Dr. J. G. Blower, Akron, was elected president of the State Medical Board, at the mid-winter business session of the Board held in Columbus, January 5.

Dr. J. F. Wuist, Dayton, was elected vice president, and Dr. Stewart J. Hagen, Cincinnati, treasurer.

Dr. H. M. Platter was re-appointed by the Board as secretary. Professor S. E. Rasor was re-named entrance examiner and Miss Caroline McKee chief examiner for nurse registration.

The certificate of George W. Thompson, Cleveland, to practice electro-therapy and chiropractic in Ohio was revoked on the grounds that he had exceeded the limits of his certificate and had been engaged in the practice of medicine and surgery.

The Board restored to Elizabeth M. Overhulse, Portsmouth, her certificate to practice medicine and surgery, which had been suspended two years ago.

The Board adopted the following additional regulation governing accredited schools of nursing, effective July 1, 1932, which in effect means that the Board will not recognize or approve schools of nursing of hospitals which employ other than Ohio registered nurses or permit other than Ohio registered nurses to practice therein:

"Accredited schools of nursing whose graduates will be candidates for the Ohio R.N. will hereafter (July 1, 1932) be located or connected with hospitals which require nursing to be practiced by Ohio registered nurses. Such hospitals shall require nurses practicing therein to be Ohio registered. Pupil nurses enrolled in the training school are exempt from this requirement."

The Board, in adopting the foregoing regulation, was of the opinion that close adherence to this regulation by hospitals operating accredited schools of nursing would have a tendency to elevate the standards of the nurse training schools, as well as the hospital, and would aid materially in a solution of the unemployment question among Ohio registered nurses, especially acute now due to the economic depression.

Licenses to practice medicine and surgery in Ohio were granted to 30 medical school graduates who took the December examinations given by the Board. Certificates of practice were issued to 4 osteopaths, 1 chiropractor, 5 mechano-therapists, 4 electro-therapists, 1 cosmetic-therapist, and 12 masseurs.

Edward J. Amberg, Toledo, and Gordon B. Taylor, Cleveland, with grades of 86 tied for first place in the medical examinations. Marvin R. Hannum, Toledo, was second with a grade of 85.2.

Those granted medical and surgical licenses were as follows:

Joseph D. Fitzgerald, Cincinnati, Creighton Medical School; Morris G. Carmody, Painesville, Georgetown University; Richard V. Clifford, Youngstown, Georgetown University; Francis E. Cunningham, Cincinnati, Georgetown University; Norbert S. Greene, Cleveland, Georgetown University; Karl L. Lehmiller, Canton, Georgetown University; Dominic P. Donisi, Middletown, Hahnemann Medical College; Giles Wolverton, Greenville, Jefferson Medical College; John L. Quinn, Steubenville, Jefferson Medical College; Vincent C. Nipple, Clinton, Jefferson Medical College.

Lawrence C. Grosh, Jr., Toledo, Johns Hopkins University; Fred F. Shepard, Cincinnati, New York Homeopathic Medical College; Orville M. Wright, Dayton, Northwestern University; William M. Stauffer, Quakertown, Pa., Rush Medical College; Edward J. Amberg, Toledo, St. Louis University; John J. Flannery, Cincinnati, St. Louis University; William J. Fornes, Cleveland, St. Louis University; Herman G. Rubin, Akron, Temple Medical College; Louis E. Baron, Cleveland, Tufts Medical College; Edwin R. Jacka, Toledo, Tulane University; Warren L. Strohmenger, St. Bernard, University of Louisville.

Leon S. Hirsh, Cincinnati, University of Louisville; Joseph C. Hall, Youngstown, University of Louisville; Alexander Slavcoff, Youngstown, University of Maryland; Marvin R. Hannum, Toledo, University of Maryland; Boyd W. Travis, Toledo, University of Pennsylvania; Lloyd E. Seyler, Cleveland, University of Pennsylvania; Gordon B. Taylor, Cleveland, University of Rochester; William N. Vigor, Cleveland, Western Reserve University; Pedro G. Acosta, Rome, N. Y., University of St. Thomas.

Reciprocity licenses in medicine and surgery were granted the following: Roy D. Arn, Dayton, University of Michigan; Earl R. Bush, Cincinnati, Indiana University; Andrew S. Burton, Newark, Meharry Medical College; Everett N. Collins, Cleveland, Rush Medical College; Clark S. Fitzmorris, Cincinnati, Colorado University Medical School; Frederick W. Gillig, Tiffin, Loyola University; Lewis M. Henry, Cincinnati, University of Tennessee; Frank H. Maxwell, Mansfield, University of Michigan; Ronald J. McNamara, Cincinnati, St. Louis University; Stanford W. Mulholland, Springfield, University of Michigan; Maurice Rosenzweig, Elyria, Jefferson Medical College; Ralph H. Ruhmkorff, Portsmouth, Loyola University; Wendell M. Steele, Lafferty, St. Louis University; Bernhard Steinberg, Toledo, Boston University; Howard B. Weaver, Mineral City, Rush Medical College; George L. Miller, Cleveland, University of Buffalo.

NEWS NOTES of OHIO

Wellsville—Dr. J. S. McCulloch was installed as president of the local Kiwanis Club at the annual holiday party given by the club.

Cleveland—Dr. Lee H. Ferguson, director of health services at Western Reserve University, reported on a plan for a five-year study of tuberculosis among students, at the recent meeting of the American Student Health Association held in New York City.

Middletown—The marriage of Miss Ruth E. Price and Dr. Walter Reese, both of this city, has been announced by Mr. and Mrs. W. R. Price, parents of the bride.

Dayton—Dr. Franklin I. Shroyer was a speaker at the recent meeting of the Radiological Society of North America at St. Louis.

Akron—Dr. Oscar Hayes has been elected chairman of the Summit County Veterans' Association.

Sidney—Dr. C. C. Hussey has resumed active practice following a six-weeks illness.

Columbiana—Dr. F. W. Trader discussed "The Future or Trend in Medicine" at a recent meeting of the local Rotary Club.

Findlay—Socialization of medicine in Europe has dealt the medical profession there a heavy blow, Dr. Frank M. Wiseley, who recently returned from post-graduate work in Europe, told the local Kiwanis Club at a recent meeting.

Akron—The Fathers' Club of the Kent School was addressed recently by Dr. R. S. Friedley.

Findlay—The diseases which take the heaviest death toll among adults were discussed before the Findlay Rotary Club, recently, by Dr. John V. Hartman.

Wilmington—Dr. and Mrs. Kelley Hale attended the recent meeting of the Radiological Society of North America at St. Louis.

Greenfield—Dr. W. H. Ambrose has been notified of his promotion to lieutenant colonel in the Organized Medical Reserve Corps.

Lewisburg—Dr. Karl W. Horn, who has been in practice here for the past nine years, will leave soon for Ann Arbor, Michigan, where he has accepted an appointment on the staff of the University of Michigan Hospital. His practice here will be taken over by Dr. R. H. Jones, his associate for the past six months.

Shadyside—Dr. E. D. Piper has announced his candidacy for the Republican nomination for coroner of Belmont County at the forthcoming primaries.

Middletown—Dr. E. N. Clark has been appointed township physician of Lemon Township, succeeding Dr. Mabel White Gardiner.

Bucyrus—County Commissioners of Crawford County have appointed Dr. D. G. Arnold physician at the county home and Dr. W. E. Baker physician at the county jail.

Akron—Dr. Louis Karnosh, Cleveland, addressed a dinner meeting of the Summit County Dental Society at the Mayflower Hotel.

Dover—Announcement has been made of the engagement of Miss Cordelia Hoffman, graduate nurse, and Dr. Edgar C. Davis, local physician.

Marion—Dr. N. Sifritt, health commissioner of the City of Marion and Marion County, has been elected chairman of the Marion County Chapter of the Red Cross.

Sandusky—Dr. F. C. Burket has been appointed by the county commissioners physician at the county home and Dr. J. L. Carroll has been named physician at the county jail.

Fremont—Dr. Sherman McKenney has been appointed coroner of Sandusky County, succeeding Dr. F. M. Teeple, who resigned to accept an appointment as county health commissioner.

Cleveland—Dr. Milton B. Cohen has been granted a private airplane pilot's license by the Department of Commerce.

Cleveland—Dr. J. J. Selman was elected grand marshal of Phi Delta Epsilon, national medical fraternity at the recent convention of the fraternity here.

Cleveland—Dr. J. J. Thomas, school physician at the University School for the past thirty years, was recently honored by being presented a gold monogrammed football in recognition of his long service on the school's faculty.

Cleveland—Dr. Fred Adelstein has returned from post-graduate work in eye, ear, nose and throat work at Vienna.

Bowling Green—Dr. Ira O. Denman, Toledo, has opened an office here for the practice of eye, ear, nose and throat work.

Lima—Dr. Frederic G. Maurer and Dr. Edmund H. Hedges of Lima were the guest speakers at the annual tri-county medical meeting held December 7, at the Clinton Memorial Hospital, St. Johns, Michigan. At the afternoon program, Dr. Maurer spoke on "Diabetes in General Practice" and Dr. Hedges on "Some Urological Thoughts in General Practice". In the evening, Dr. Maurer read a paper on "The Internist and Silent Upper Urinary Tract Pathology", and Dr. Hedges one on "Urological Discussion and Lantern Slides of Silent Lesions".

Columbus—Phi Rho Sigma, medical fraternity, is sponsoring the formulation of a history of the practice of medicine and medical education of Franklin County. The work of gathering material for the publication has been started by Dr. Jonathan Forman, vice president and editor of publications of Phi Rho Sigma. Physicians who have in their possession material, books, pictures, etc., can assist in this undertaking by sending the material to Dr. Forman, 394 East Town St., Columbus, for copying and insertion in the historical publication.

News Notes From County Societies and Academies

First District

ACADEMY OF MEDICINE OF CINCINNATI

(H. H. Shook, M.D., Secretary)

January 4—Medical Section. Union Central Building. Program: "Why the Increase in the Death Rate in Heart Disease in the Fifth and Sixth Decades of Life", by Dr. Julian E. Benjamin. Discussion opened by Dr. William Muhlberg and Dr. Floyd P. Allen. "Upper Abdominal Conditions Simulating Heart Disease", by Dr. George B. Topmoeller. Discussion opened by Dr. Clifford J. Straehley.

January 11—Surgical Section. Union Central Building. Program: "Maggot Treatment of Osteomyelitis", by Dr. Eslie Asbury and Dr. Samuel Flook; "Interpretations of Ano-Rectal Symptoms", by Dr. A. G. Carmel. Discussion opened by Dr. L. J. Krouse and Dr. C. E. Howard.

January 18—Specialty Section. Union Central Building. Program: "Uveitis Produced Experimentally by Sensitization", by Dr. A. L. Brown and Dr. Clyde Dunner; "Stereo-Protographs of the Optic Nerve in Health and Disease", by Dr. D. J. Lyle.

January 25—General Session. Union Central Building. Program: "Insulin Reaction", by Dr. E. P. Joslin, Boston.

Fayette County Medical Society met in regular session Thursday, January 7. Following the installation of new officers, Dr. Clarence I. Britt, Columbus, addressed the society on "Acute Appendicitis". A lively discussion on this subject concluded the meeting.—James F. Wilson, Secretary.

Clinton County Medical Society held its regular meeting January 5. The following program consisting of case reports was presented: "Headache of Early Nephritis", Dr. Robert Conard; "Stillbirth with Fibrous Degeneration", Dr. Elizabeth R. Shrieves; "Arrested Labor", Dr. C. A. Tribbett; "Acute Otitis Media with Nephritis Complicating Scarlet Fever", Dr. Chester E. Kinzel; "Fifteen Cases of Scarlet Fever in One Family", Dr. L. H. Fullerton; "Differential Diagnosis of Tonsilitis and Scarlet Fever", Dr. H. E. Gibson; "Signs and Symptoms of Undiagnosed Case", Dr. S. A. Crabtree; "Nephritis Following Undiagnosed Scarlet Fever", Dr. William B. Yoakley; "Two Cases of Dislocation of Hip in One Automobile Accident", Dr. William K. Hale; "Scarlet Fever without Skin Manifestations", Dr. Virgil E. Hutchens. During the business session, Drs. Conard, Fullerton and Gibson were appointed to formulate plans for the care of indigent venereal disease patients.—William L. Regan, Secretary.

Second District

Clark County Medical Society at its meeting on December 7 witnessed talking films on three major surgical operations prepared by Dr. H. O. Jones, professor of gynecology, Northwestern University Medical School. The meeting was held at the Shawnee Hotel where dinner was served preceding the program. Many physicians from surrounding counties attended.—News Clipping.

Clark County Medical Society at a luncheon meeting, Wednesday, December 16, at the Shawnee Hotel, elected the following officers for the ensuing year: President, Dr. E .H. Long, South Vienna; vice president, Dr. C. W. Evans, Springfield; treasurer, Dr. F. P. Anzinger, Springfield; secretary, Dr. E. C. Nehl, South Charleston. Preceding the business session, an interesting program was presented. Dr. F. P. Anzinger gave a report on a case of acute tularemia, said to be the first case in Clark County. Dr. C. L. Hartsock, Cleveland Clinic, read a paper on "Indigestion", stressing the points most commonly met in general practice.—News Clipping.

Darke County Medical Society held its regular monthly meeting, Friday, January 8, at the James Hotel, Greenville. The following new officers were installed: President, Dr. Charles F. Frankman, Greenville; vice president, Dr. B. F. Metcalf, Greenville; secretary-treasurer, Dr. W. D. Bishop, Greenville; legislative committeeman, Dr. William T. Fitzgerald; medical defense committeeman, Dr. O. P. Wolverton; delegate to state meeting, Dr. C. I. Stephen, Ansonia; alternate to state meeting, Dr. J. E. Gillette, Versailles. The speaker for the evening was Dr. J. A. Link, Springfield, who spoke on "Fractures", illustrating his talk with motion pictures and lantern slides.—W. D. Bishop, Secretary.

Montgomery County Medical Society held its regular meeting January 15 at the St. Elizabeth Hospital, Dayton. Dinner was served by the hospital. The program consisted of case reports by members of the hospital staff.—Bulletin.

Preble County Medical Society was addressed by Dr. G. F. McKim, Cincinnati, on "Prostatic Lesions" at its regular December meeting. Dr. McKim used films to illustrate his address. Forty-one were present, including a number of physicians from Dayton, Greenville and Richmond, Indiana.—C. M. Treffinger, Secretary.

Third District

Auglaize County Medical Society held its annual meeting Thursday, December 10, at Wapakoneta, with 16 members present. The following officers were elected: President, Dr. F. F. Fledderjohann, New Bremen; vice president, Dr. R. C. Hunter, Wapakoneta; secretary-treasurer, Dr. Charles C. Berlin, Wapakoneta; censor, Dr. E. F. Heffner, Wapakoneta; delegate to the state meeting, Dr. Charles P. McKee, St. Marys; alternate, Dr. R. C. Hunter, Wapakoneta; legislative committeeman, Dr. Guy E. Noble, St. Marys, and medical defense committeeman, Dr. T. A. Campbell, Wapakoneta. The special feature of the program consisted of a carefully prepared and highly instructive paper by Dr. J. R. Tillotson, Lima, on "Some Difficult Fractures". The paper evoked animated and extended discussion from many of those present, testifying to the practical interest in the subject.—Charles C. Berlin, Secretary.

Hancock County Medical Society met in regular session January 6 at the Elks' Club at Findlay. The program was presented by Dr. E. J. Thomas and Dr. F. M. Wiseley, both of Findlay. Dr. Thomas read a paper on "*X*-ray Therapy" and Dr. Wiseley spoke on "Observations in the Clinics of Vienna". An interesting discussion followed each paper.—H. O. Crosby, Secretary.

Logan County Medical Society held a dinner meeting December 11 at the Hotel Ingalls, Bellefontaine, the honored guest of the evening being Dr. W. S. Philips, veteran Belle Center physician, who that week completed 50 years of active practice. As a token of respect for the veteran practitioner, the members of the society presented him with a Cogswell chair. The presentation address was made by Dr. J. P. Harbert, Bellefontaine, following brief introductory remarks by Dr. Ben S. Leonard, West Liberty, retiring president of the society and toastmaster. Dr. Leonard himself completed 50 years of service in the profession in 1930. Dr. Philips has been active for many years in medical organization and at one time served as president of the Northwest Ohio Medical Association. The scientific program was presented by Dr. Norris W. Gillette, Dr. A. H. Schade and Dr. Joseph Gould, all of Toledo. Dr. Gillette exhibited two motion pictures, one showing the anatomy of the neck and another showing the operation for removal of a goiter. He lectured as the films were shown. Dr. Schade, assisted by Dr. Gould, lectured as he exhibited films showing microscopic views of goiter pathology. Following the program, officers for 1932 were installed.—W. H. Carey, Secretary.

Logan County Medical Society at its first meeting of 1932, held January 8 at Hotel Logan, Bellefontaine, was addressed by Dr. C. L. Bonifield, Cincinnati, on the subject, "Civilization".—News Clipping.

Marion Academy of Medicine, at its regular annual meeting, December 1, elected the following officers for the ensuing year: President, Dr. E. L. Brady; vice president, Dr. Maud Bull; secretary, Dr. Kenneth D. Smith; treasurer, Dr. J. W. Bull; delegate to state meeting, Dr. F. E. Mahla; alternate, Dr. C. L. Baker, Kirkpatrick. A considerable portion of the meeting was devoted to a discussion of the question of charity work. After it had been pointed out that the profession is doing an unusually large amount of charity work, two committees were named to investigate the question more thoroughly and report back to the society. Dr. J. W. Jolley was named chairman of a committee to confer with county, city and township officials and to present the recommendation of the Academy that the same medical care now being furnished inmates of county institutions be given to indigents of the city and county. Dr. J. W. Bull was appointed chairman of a second committee to meet with the same officials in an attempt to work out a permanent solution for the medical charity question. The sentiment of the Academy was that the county, city and townships should provide funds for the care of the indigent sick who are bedfast and unable to attend the charity clinics conducted at the Marion City Hospital.—News Clipping.

Seneca County Medical Society at its regular meeting December 17 at the Shawhan Hotel, Tiffin, was addressed by Dr. C. F. Daniel, Tiffin, on "Surgical Treatment of Appendicitis". A general discussion by the 20 members present followed the paper.—News Clipping.

Van Wert County Medical Society held a buffet supper meeting January 5 at the Y.W.C.A. Building, Van Wert. Members of the Van Wert City Board of Health, Van Wert County Board of Health, the Convoy Board of Health, and the health nurses of Van Wert and Van Wert County, in addition to physicians from Rockford, Grover Hill and Paulding, were guests of the society. The principal address of the evening was made by Dr. H. G. Southard, state director of health, and Dr. J. D. Boylan, Milford Center. The program was arranged by Dr. C. G. Church.—News Clipping.

Fourth District

ACADEMY OF MEDICINE OF TOLEDO AND LUCAS COUNTY

(A. F. Hancuff, M.D., Secretary)

January 8—Annual dinner followed by annual meeting with reports and election of officers.

January 15—Section on Pathology, Experimental Medicine and Bacteriology. Program: "Multiple Sclerosis", Dr. C. E. Price; "Hemorrhagic Gastric Ulcer", (Case Report), Dr. R. C. Young; "Multiple Melanoma", wtih lantern slide demonstration (Case Report), Dr. A. H. Schade; "Unusually Small Cirrhotic Liver—Exhibition of Specimen", Dr. A. H. Schade.

January 22—Medical Section. Program: "Classification—Etiology and Pathology", Dr. A. L. Bershon; "Medical Management", Dr. Carl S. Mundy; "Surgical Problems in Arthritis", Dr. B. J. Hein. Discussants, Dr. J. T. Murphy and Dr. B. G. Chollett.

January 29—Surgical Section. Program: "An Analysis of 250 Goiter Cases", Dr. N. W. Gillette; discussant, Dr. Kinsley Renshaw; "A Case of Acute Appendicitis with a Ruptured Duodenal Ulcer, With a Discussion of Pyloroplasty" (Case Report), Dr. B. G. Shaffer; "Carcinoma of the Prostate With Metastasis" (Case Report), Drs. E. B. Gillette and A. H. Schade.—Bulletin.

Four County Medical Society met at the Memorial Hospital, Wauseon, Thursday, January 7, with 50 physicians from Defiance, Fulton, Henry and Williams counties, and several surrounding counties, in attendance. The program was received enthusiastically by those present. Dr. Charles Lakoff, Detroit, gave an illustrated lecture on "Acute Abdomen" and Dr. S. G. Myers, Detroit, read a paper on "Interpretation of Gastric Symptoms from the Medical Viewpoint".—D. J. Slosser, Defiance, Secretary.

Putnam County Medical Society held a luncheon meeting at the Du Mont Hotel, Ottawa, January 5 with 15 members present. Dr. Paul M. Holmes, Toledo, staff member at the Toledo Tuberculosis Hospital, gave a timely talk on "Diagnosis of Pulmonary Tuberculosis". Dr. B. J. Hein, Toledo, councilor of the Fourth District, attended the meeting and gave a talk on organization activities, after which he read an interesting paper on "Fractures".—H. A. Neiswander, Corresponding Secretary.

Sandusky County Medical Society at its regular meeting December 17 at Fremont elected officers for 1932 and listened to an interesting paper on "Food Allergy", by Dr. Karl D. Figley, Toledo. The following officers were elected: President, Dr. C. L. Smith, Fremont; vice president, Dr. D. W. Philo, Fremont; secretary-treasurer, Dr. L. N. Bates, Fremont; legislative committeeman, Dr. Charles Wehr, Bellevue; medical defense committeeman, Dr. H. K. Shumaker, Bellevue; censor, Dr. C. R. Pontius, Fremont; delegate to state meeting, Dr. J. L. Curtin, Fremont; alternate, Dr. J. C. Boyce, Fremont.—L. N. Bates, Secretary.

Wood County Medical Society held its regular monthly meeting December 17 at the Women's Club, Bowling Green. Following a dinner, a scientific program was presented. Dr. Norris W. Gillette, Toledo, read an excellent paper on "New Nomenclature of Goiter". The presentation was illustrated by lantern slides and Dr. A. H. Schade, Toledo, discussed the pathology of this subject. A film on "Colles Fracture" was shown by a representative of the Petrolagar Laboratories. Among the guests were Dr. Charles Lukens, Dr. Ira O. Denman, and Dr. J. J. Gould, Toledo. Following the program, a business session was held at which the following officers for 1932 were elected: President, Dr. O. S. Canright, Haskins; vice president, Dr. F. L. Sterling, Bowling Green; secretary-treasurer, Dr. F. V. Boyle, Bowling Green; correspondent for *The Journal*, Dr. R. N. Whitehead, Bowling Green; legislative committeeman, Dr. E. A. Powell, North Baltimore; medical defense committeeman, Dr. T. O. Whitacre, Bowling Green; delegate to state meeting, Dr. E. D. Foltz, North Baltimore; alternate, Dr. E. H. Mercer, Bowling Green.—R. N. Whitehead, Correspondent.

Fifth District

ACADEMY OF MEDICINE OF CLEVELAND

(Clarence H. Heyman, M.D., Secretary)

January 8—Experimental Medicine Section. Program, arranged by the Department of Biochemistry, Western Reserve University: "Range of Calcium and Phosphorus in the Serum of Normal Women", J. W. Mull, Ph.D., and Dr. A. H. Bill; "A Method of Combining the Hemoglobin Estimation with the Red Cell Count", R. W. Heinle, A.B.; "Influence of Parenterally Administered Iron on the Anemia of the Rat", F. C. Bing, Ph.D., M. W. Eveleth, A.B., and V. C. Myers, Ph.D.; "Excretion of Methyl Uric Acids Following the Ingestion of Methyl Xanthines", R F. Hanzal, Ph.D.; "Influence of Insulin on the Blood Diastase", Eric Reid, Ph.D.; "Guanidine Content of the Blood in Renal Disease", Jerome E. Andes, M.S.; "Acid-Base Studies in Different Types of Renal Disease", Dr. C. T. Way; "Colloid Osmotic Pressure of the Plasma", E. Muntwyler, Ph.D., and D. A. Binns, M.A.; "Studies on the Creatine Content of Heart Muscle", Dr. D. P. Seecof, C. R. Linegar, A.B., and V. C. Myers, Ph.D.—Bulletin.

No other Academy or other Section meetings were held during January.

Lorain County Medical Society held its annual meeting December 8 at the Elyria Memorial Hospital with 52 members in attendance. The following officers for the ensuing year were elected:

President, Dr. David Thomas, Lorain; vice president, Dr. A. S. McKitrick, Elyria; secretary-treasurer, Dr. W. E. Hart, Elyria; legislative committeeman, Dr. S. V. Burley, Lorain; delegate to State Meeting, Dr. S. V. Burley, Elyria; alternate, Dr. John P. Rankin, Elyria. Following the election of officers, scientific motion pictures with sound were shown.—W. E. Hart, Secretary.

Lorain County Medical Society held its regular January meeting, January 12, at the Hotel Lorain. Dinner was served at 6 p. m. The principal address of the evening was made by Dr. Clyde L. Cummer, Cleveland, councilor of the Fifth District. Dr. Cummer spoke on "Treatment of Some of the Common Skin Diseases", using slides to illustrate his talk.—Bulletin.

Sixth District

The Union Medical Association of the Sixth District held its 22nd session at the Elks' Club, Canton, Wednesday, January 13. The morning program consisted of the following presentations: "Some of the Newer Anesthetics—and Report of a Case of Duhring's Disease", Dr. L. A. Adair, Wooster; "Results of *X*-ray Treatment of Malignancy of the Mediastinum", Dr. John G. Selby, Akron. Following a luncheon at noon, a business session was held at which officers for the ensuing year were elected. The afternoon program consisted of two papers, one on "Diabetes Mellitus—A Definition", by Dr. Charles E. Held, Akron, and one on "Backache of Gynecological Origin", by Dr. Marion Douglas, Cleveland. Officers of the Association during 1931 were President, Dr. J. G. Blower, Akron; secretary-treasurer, Dr. J. H. Seiler, Akron, and councilor, Dr. Harry S. Davidson, Akron.—Program.

Ashland County Medical Society at its regular meeting, January 8, at Samaritan Hospital, was addressed by Dr. Arthur G. Hyde, superintendent of the Massillon State Hospital, on the various types of mental diseases and the work being done at the hospital. An interesting paper on "Hemorrhoids—Classification, Diagnosis, and Accepted Treatment", was read by Dr. E. L. Clem, Ashland. The meeting was well attended by members of the society and by the graduate and student nurses of Samaritan Hospital.—Paul E. Kellogg, secretary.

Portage County Medical Society held its first meeting of 1932 on January 7 at the Nurses' Home of the Portage County Hospital upon the invitation of Superintendent Hendee. The meeting was opened by an address by Dr. A. O. DeWeese, Kent, retiring president of the society, and inauguration of newly-elected officers. Addresses were made by two guest speakers. Dr. John Dickenson, visiting surgeon, Charity Hospital, Cleveland, spoke on "Cranio-Cerebral Injuries", and Dr. W. S. Duncan, Cleveland Clinic, on "Fractures of Tibia and Fibula".—Program.

Richland County Medical Society held its annual banquet and election of officers at the Mansfield-Leland Hotel, Friday, December 18. The following officers were elected: President, Dr. W. H. Buker, Bellville; vice president, Dr. C. H. Bell, Mansfield; secretary, Dr. P. A. Stoodt; treasurer, Dr. Mabel Emery; medical defense committeeman, Dr. Harro Woltman; delegate to state meeting, Dr. J. S. Hattery; alternate, Dr. D. C. Lavender. The principal address following the business session was made by Dr. Walter Stern, Cleveland, on "Newer Methods in the Treatment of Fractures". Dr. Stern used *X*-ray plates and fracture appliances to illustrate his lecture.—News Clipping.

Stark County Medical Society held its annual meeting Tuesday, January 12, at the Elks' Club, Canton. At the completion of the business session, at which officers were elected, Dr. Clarence Heyman, Cleveland, addressed the society on "Fractures of the Hip".—Bulletin.

Summit County Medical Society met in regular session, January 5, at the Akron City Club. The following program, consisting of a symposium on "The Progress of 1931", was presented: "Anesthesia", Dr. A. S. McCormick; "Pediatrics", Dr. R. S. Friedley; "Surgery", Dr. J. L. McEvitt; "Pathology", Dr. F. C. Potter, and "Medicine", Dr. F. A. Smith.—Bulletin.

Seventh District

Tuscarawas County Medical Society held its first meeting of 1932 on January 14 at the New Philadelphia city hall. The principal address of the evening was made by Mr. George B. Cobb, district supervisor of the Bureau of Vocational Rehabilitation, who described the work of the bureau.—Bulletin.

Eighth District

Athens County Medical Society at its regular meeting January 4 at the American Legion Home, Athens, was addressed by Dr. John Dudley Dunham, Columbus. The topic of Dr. Dunham's paper was "Diseases of the Esophagus".—News Clipping.

Guernsey County Medical Society elected the following officers at its regular meeting held December 3 at Cambridge: President, Dr. M. S. Lawrence, Quaker City; vice president, Dr. W. L. Denny, Cambridge; secretary-treasurer, Dr. C. C. Headley, Cambridge; correspondent for *The Journal*, Dr. O. Reed Jones, Cambridge; legislative committeeman, Dr. George F. Swan, Cambridge; medical defense committeeman, Dr. Fred Lane, Cambridge; delegate to state meeting, Dr. B. A. Souders, Cambridge; alternate, Dr. C. A. Craig, Cambridge. Dr. H. R. Neeland was appointed chairman of the luncheon committee.

A committee was named to draft a resolution for consideration by the society favoring an insurance plan for World War Veterans, as suggested by Dr. H. H. Shoulders, Nashville, Tennessee. It was voted to have the resolution when officially adopted submitted to the two Ohio United States Senators.—O. Reed Jones, Correspondent.

Guernsey County Medical Society held a turkey dinner and frolic at the Berwick Hotel, Cambridge, the evening of December 17. Wives of the members were guests, there being 22 couples present. Following the installation of officers elected at the meeting two weeks before, a program of entertainment was presented, consisting of cards, games and a spelling bee. Mrs. C. A. Craig won the card prize and Dr. Gordon Lawyer the spelling contest which was staged by Dr. A. B. Headley.—O. Reed Jones, Correspondent.

Guernsey County Medical Society met in regular session Thursday noon, January 7, at the Romance Restaurant, Cambridge. Committee appointments were announced by the president, Dr. M. S. Lawrence, and plans for the new year discussed. A committee was named to outline methods for establishing a central physicians' credit and collection bureau. An address on "Treatment of Sinus Infections" was made by Dr. C. C. Headley. Three new members were admitted, Drs. E. G. Ditch, Caldwell; A. C. Ormond, Byesville, and H. W. Arndt, Lore City.—O. Reed Jones, Correspondent.

Muskingum County Medical Society held a joint meeting, Wednesday evening, January 6, with the Muskingum Valley Dental Association, at the American Legion rooms, Zanesville. Addresses were given by Dr. Paul J. Aufderheide, Cleveland, president-elect of the Ohio State Dental Association, on "Oral Pathology", with lantern slides, and Dr. W. I. Jones, Columbus, on "Dental Hygiene."—Bulletin.

Perry County Medical Society at its regular meeting December 28 at the Park Hotel, New Lexington, was addressed by Dr. Paul D. Scofield, Columbus, on "Spinal Anesthesia".—News Clipping.

Perry County Medical Society at its regular meeting, January 18, at the Park Hotel, New Lexington, was addressed by Dr. Albert B. Landrum, Columbus.—Bulletin.

Ninth District

Scioto County—Regular meeting of the Hempstead Academy of Medicine was held January 11 at the Recreational Hall Nurses' Home. Dr. Julian E. Benjamin, Cincinnati, was the essayist, speaking on "Why the Increase in the Death Rate in Heart Disease in the Fifth and Sixth Decades of Life". The discussion was opened by Dr. William Muhlberg, Cincinnati. A buffet supper was served at the conclusion of the program which was arranged by Dr. H. F. Rapp.—Bulletin.

Hocking County Medical Society held its annual business meeting at the Cherrington Hospital, Logan, on December 17. The following officers were elected: President, Dr. H. M. Boocks; vice president, Dr. J. L. Webb; secretary-treasurer, Dr. M. H. Cherrington. At the conclusion of the business session, Dr. Boocks made an interesting talk on "The Costs of Medical Care".—M. H. Cherrington, Secretary.

Tenth District

COLUMBUS ACADEMY OF MEDICINE

(John H. Mitchell, M.D., Secretary)

January 4—At the first meeting of the Columbus Academy of Medicine in 1932, the following newly-elected officers were installed: President, Dr. James H. Warren; vice president, Dr. George I. Nelson; secretary-treasurer, Dr. John H. Mitchell; delegates to state meeting, Drs. John B. Alcorn, I. B. Harris, E. J. Emerick, J. H. J. Upham, and John M. Thomas. Annual reports were read by the retiring officers and committee chairmen. Special reports on progress during 1931 were read by Dr. Wells Teachnor, Jr., for the section on surgery; Dr. G. I. Nelson, for the section on medicine, and Dr. H. W. Koerper for the section on obstetrics. The following committees were appointed by Dr. Warren, the incoming president:

Medical progress—Dr. Carl D. Postle, chairman, ophthalmology and oto-larynology; Dr. J. F. Baldwin, surgery; Dr. Charles A. Doan, medicine.

Public health—Dr. James A. Beer, chairman; Dr. E. G. Horton, Dr. Nelson C. Dysart.

Legislative—Dr. John M. Thomas, chairman; Dr. I. B. Harris, Dr. E. D. Helfrich.

Library—Dr. Leslie Bigelow, chairman; Dr. John Dudley Dunham, Dr. Albert D. Frost.

Program—Dr. C. C. Sherburne, chairman; Dr. E. J. Stedem, Dr. L. H. VanBuskirk, Dr. Jonathan Forman.

Membership—Dr. Paul Scofield, chairman; Dr. Frank Watson, Dr. R. O. Adams, Dr. A. B. Walton.

Civic Affairs—Dr. Sylvester Goodman, chairman; Dr. Andre Crotti, Dr. George Harding, II, Dr. J. H. J. Upham, Dr. William H. Pritchard, Dr. John Edwin Brown.

January 11—The following program was presented at the regular meeting of the Columbus Academy of Medicine held at the Columbus Public Library on January 11: "Narcolepsy", by Dr. George T. Harding, III, and "The Diagnosis and Treatment of Pernicious Anemia", by Dr. Donald E. Yochem.

Ross County Medical Society held its annual election of officers at a dinner meeting at the Warner Hotel, Chillicothe, December 3. The following were elected: President, Dr. Glen Nisley, Chillicothe; vice president, Dr. H. R. Brown, Chillicothe; secretary-treasurer, Dr. W. C. Breth,

Chillicothe; legislative committeeman, Dr. H. R. Brown; medical defense committeeman, Dr. L. T. Franklin, Chillicothe; delegate to state meeting, Dr. O. P. Tatman, Chillicothe; alternate, Dr. A. E. Merkle, Chillicothe. Following the business session, Dr. Hugh Beatty, Columbus, addressed the society on "Malignancies of the Nose and Throat."—W. C. Breth, Secretary.

Ross County Medical Society met January 7 at the Warner Hotel, Chillicothe, with 15 members in attendance. Dr. Albert D. Frost, Columbus, the guest speaker of the evening, read a paper on "Cooperation of the Oculist With the General Practitioner". Dr. E. W. Harris, Columbus, was also a guest of the society.—W. C. Breth, Secretary.

Crawford County Medical Society and the Crawford County Bar Association held a joint meeting the evening of January 4 in the Crawford County Courthouse, Bucyrus. The principal address on the program was made by Dr. Walter G. Stern, Cleveland, who spoke on "The Doctor in Court—From the Doctor's Standpoint". The discussion was opened by J. D. Sears, Crawford County prosecutor, and Common Pleas Judge C. U. Ahl.—Bulletin.

NEW COUNTY SOCIETY OFFICERS

In addition to results of annual elections reported in the foregoing County Society News, the following county societies have elected officers for 1932:

Adams County—President, Dr. R. L. Lawwill, Seaman; vice-president, Dr. Hazel Sproull, West Union; secretary-treasurer, Dr. O. T. Sproull, West Union (re-elected); legislative and medical defense committeeman, Dr. S. J. Ellison, West Union; delegate to State Meeting, Dr. Ray Vaugeh, West Union, R.F.D. No. 2; alternate to be appointed.

Ashland County—President, Dr. W. F. Ewing, Ashland; president-elect, Dr. H. M. Gunn, Ashland; secretary-treasurer, Dr. Paul E. Kellogg, Ashland; legislative committeeman, Dr. George Emery; board of Censors, Dr. E. L. Clem; delegate to State Meeting, Dr. L. G. Sheets; alternate, Dr. E. G. Grover.

Athens County—President, Dr. L. D. Nelson, The Plains; vice-president, Dr. C. E. Welch, Nelsonville; secretary-treasurer, Dr. T. A. Copeland, Athens (re-elected); correspondent for *The Journal*, and legislative committeeman, Dr. J. L. Henry, Athens; medical defense committeeman, Dr. A. L. Pritchard, Nelsonville; delegate to State Meeting, Dr. C. S. McDougall, Athens.

Belmont County—President, Dr. W. Miles Garrison, St. Clairsville; president-elect, Dr. G. W. Ramsey, Powhatan; secretary-treasurer, Dr. C. W. Kirkland, Bellaire, (re-elected); legislative committeeman, Dr. R. H. Wilson; medical defense committeeman, Dr. D. O. Sheppard, Barnesville; program committee, Drs. F. R. Dew, Maskrey Wilson and Dr. Garrison.

Coshocton County—President, Dr. R. E. Hopkins, Coshocton; vice president, Dr. J. C. Briner, West Lafayette; secretary-treasurer, Dr. J. D. Lower, Coshocton, (re-elected); legislative committeeman, Dr. E. M. Wright, Coshocton; medical defense committeeman, Dr. D. M. Criswell, Coshocton; delegate to State Meeting, Dr. Wilmer Hammond, West Lafayette; alternate, Dr. J. C. Briner, West Lafayette.

Cuyahoga County—(Academy of Medicine of Cleveland)—President, Dr. H. G. Sloan; vice-president, Dr. Harold Feil; secretary-treasurer, Dr. Clarence H. Heyman, (re-elected) correspondent for *The Journal*, H. Van Y. Caldwell; legislative and medical defense committeeman, Dr. J. E. Tuckerman.

Defiance County—President, Dr. George DeMuth, Sherwood; vice-president, Dr. Paul B. Newcomb, Defiance; secretary-treasurer and correspondent for *The Journal*, Dr. D. J. Slosser, Defiance, (re-elected); legislative and medical defense committeeman, Dr. J. U. Fauster, Defiance; delegate to State Meeting, Dr. George DeMuth, and alternate, Dr. Newcomb.

Erie County—President, Dr. Henry W. Lehrer, Sandusky (re-elected); vice-president, Dr. Lyle S. Hill, Sandusky; secretary-treasurer and correspondent for *The Journal*, Dr. George A. Stimson, Sandusky (re-elected); delegate to State Meeting, Dr. W. T. Fenker, Sandusky, and alternate, Dr. F. H. Houghtaling, Sandusky.

Harrison County—President, Dr. A. C. Grove, Jewett; vice-president, Dr. R. P. Rusk, Cadiz; secretary-treasurer and correspondent for *The Journal*, Dr. W. C. Wallace, Hopedale; legislative committeeman, Dr. Joseph McElhattan, Freeport; medical defense committeeman, Dr. J. A. McGrew, New Athens; delegate to State Meeting, Dr. Groves or Dr. Rusk; alternate, Dr. Wallace.

Henry County—President, Dr. T. P. Delventhal, Napoleon; vice-president, Dr. C. G. Hissong, Hamler; secretary-treasurer, and correspondent for *The Journal*, Dr. F. M. Harrison, Napoleon, (re-elected); legislative committeeman, Dr. H. F. Rohrs, Napoleon; medical defense committeeman, Dr. Thomas Quinn, Napoleon; delegate to State Meeting, Dr. Quinn; alternate, Dr. Delventhal.

Highland County—President, Dr. J. C. Bohl, Hillsboro; vice-president, Dr. H. H. Lowe, Leesburg; secretary-treasurer and correspondent for *The Journal*, Dr. W. B. Roads, Hillsboro, (re-elected); legislative and medical defense committeeman, Dr. J. C. Larkin, Hillsboro; delegate to State Meeting, Dr. H. W. Chaney, Sugartree Ridge; alternate, Dr. K. R. Teachnor, Leesburg.

Jefferson County—President, Dr. Victor Biddle, Steubenville; vice-president, Dr. S. A. Harris, Steubenville; secretary-treasurer and correspondent for *The Journal*, Dr. John Y. Bevan, (re-elected); legislative committeeman, Dr. J. E. Miller, Steubenville; medical defense committeeman, Dr. Carl Goehring, Steubenville; delegate to State Meeting, Dr. Albert Weinstein, Steubenville; alternate, Dr. C. W. Sunseri, Steubenville.

Knox County—President, Dr. S. O. Gantt, Centerburg; vice-president, Dr. E. V. Ackerman, Fredericktown; secretary-treasurer, Dr. Robert L. Eastman, Mt. Vernon.

Madison County—President, Dr. R. S. Postle, London; vice-president, Dr. W. A. Holman, London; secretary-treasurer and correspondent for *The Journal*, Dr. G. C. Scheetz, West Jefferson; legislative and medical defense committeeman, Dr. H. V. Christopher, London.

Mahoning County—President, Dr. A. E. Brant, Youngstown; vice-president, Dr. J. P. Harvey, Youngstown; secretary, Dr. Wm. M. Skipp, Youngstown; treasurer, Dr. W. X. Taylor,

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PROMPT AND FULL REPORT

Youngstown; correspondent for *The Journal*, Dr. Joseph Rosenfeld, Youngstown; legislative committeeman, Dr. R. G. Mossman, Youngstown; medical defense committeeman, Dr. L. E. Phipps, Youngstown; delegates to State Meeting, Dr. Rosenfeld, and Dr. W. H. Bennett (re-elected), Youngstown; alternate to State Meeting, Dr. P. J. Fuzy, Youngstown.

Meigs County—President, Dr. P. A. Jividen, Rutland, (re-elected); vice-president, Dr. M. S. Daniels, Pomeroy; secretary-treasurer and correspondent for *The Journal*, Dr. Byron Bing, Pomeroy; legislative committeeman, Dr. Bing; delegate to State Meeting, Dr. Bing; alternate, Dr. John Philson.

Mercer County—President, Dr. M. B. Fishbaugh, Celina, R. R. No. 2; vice-president, Dr. T. H. Will, Coldwater; secretary-treasurer, Dr. Frank E. Ayers, Celina, (re-elected); censors, three-year term, Dr. Fred H. Brumm; two-year term, Dr. E. J. Willke; and one-year term, Dr. J. T. Gibbons; delegate to State Meeting, Dr. R. E. Riley, Celina; alternate, Dr. J. P. Symons, Rockford.

Miami County—President, Dr. E. T. Pearson, West Milton; vice-president, Dr. Foster Kiser, Tippecanoe City; secretary-treasurer and correspondent for *The Journal*, Dr. G. A. Woodhouse, Pleasant Hill, (re-elected); legislative and medical defense committeeman, Dr. G. E. McCullough, Troy. Delegate to State Meeting, Dr. Gainor Jennings, West Milton; alternate, Dr. I. C. Kiser, Jiqua.

Ottawa County—President, Dr. R. A. Willett, Elmore; vice president, Dr. E. D. Schuitemann, Geneva; secretary-treasurer, Dr. Cyrus E. Wood, Port Clinton.

Van Wert County—President, Dr. S. A. Edwards, Van Wert, (re-elected); vice-president, Dr. W. J. Reuter, Ohio City; secretary-treasurer, Dr. R. H. Good, Van Wert, (re-elected); correspondent for *The Journal*, Dr. A. T. Rank, Van Wert, (re-elected); legislative committeeman, Dr. C. R. Keyser, Van Wert, (re-elected); medical defense committeeman, Dr. B. L. Good, Van Wert; delegate to State Meeting, Dr. Rank; Alternate to State Meeting, Dr. F. W. Dannecker, Van Wert.

Williams County—President, Dr. A. Hathaway, Edon; vice-president, Dr. H. L. Prouty, West Unity; secretary-treasurer, Dr. B. C. Bly, Montpelier; delegate to State Meeting, Dr. J. A. Weist, Montpelier.

Deaths in Ohio

John W. Dawson, M.D., Columbus; Eclectic Medical College, Cincinnati, 1888; aged 71; died January 11 of paralysis. Dr. Dawson had practiced in Columbus for 30 years, moving there from Crooksville. Surviving are his widow, two sons, one daughter, three sisters and one brother.

Paul de la Barre, M.D., Port Clinton; School of Medicine, Western Reserve University, 1887; aged 81; died December 8. Dr. de la Barre was born in Stettin, Germany, coming to this country in 1882 and locating at Port Clinton in 1885. He was an active Mason. Surviving are three daughters.

Clyde G. Guthrie, M.D., Cincinnati; Johns Hopkins University School of Medicine, 1907; aged 52; member of the Ohio State Medical Association and a fellow of the American Medical Association; died December 14 at Holmes Hospital of heart trouble. Dr. Guthrie was a native of Indiana, Pennsylvania. Following his graduation at Johns Hopkins University, he accepted a position on the faculty as associate professor of medicine. During the World War, Dr. Guthrie was a member of the Johns Hopkins unit with the A.E.F. in France. In 1922 he became director of medicine at Lawrenceville Academy, Lawrenceville, Pa., remaining until 1927 when he located in Cincinnati. Surviving are his widow, three children, two brothers and one sister.

David Huston Miller, M.D., Newark; Columbus Medical College, 1884; aged 76; died December 6. Dr. Miller had practiced in Newark for 37 years, having practiced in Alexandria and Amity before locating there. He is survived by two daughters.

Luman Gordon Moore, M.D., Kinsman; Long Island College of Medicine, Brooklyn, 1873; aged 83; died December 18 of pneumonia. Dr. Moore, a native of Kinsman, received his premedical education at Ohio Wesleyan University and following his graduation from medical school, he entered the University of Michigan where he was graduated with a degree in pharmacy. He was president of the Kinsman Banking Company. He is survived by one daughter and one son, Dr. Luman G. Moore, II, with whom he resided.

Frank J. Myers, M.D., Green Springs; College of Medicine, University of Cincinnati, 1929; aged 33; member of the Ohio State Medical Association and a fellow of the American Medical Association; died December 31 at the Green Springs Sanitarium. He had been operated on December 18 for appendicitis. Dr. Myers following his graduation from medical school, practiced in Croton for a short time before moving to Green Springs where he took an active part in medical circles and in the American Legion. He also held degrees from Ohio University and the University of Minnesota. Surviving him are his widow, one daughter, his father and one brother, Dr. James A. Myers, Minneapolis.

Daniel W. Reddin, M.D., North Baltimore; University of Michigan Medical School, 1881; aged 72; died December 11 of pneumonia. Dr. Reddin, a native of Hancock County, was president of the Hardy Banking Company, North Baltimore. Surviving are his widow, two sons and two brothers.

Malvin V. Replogle, M.D., Bryan; Starling Medical College, Columbus, 1894; aged 62; member of the Ohio State Medical Association and of the American Medical Association; died December 31. Despondent over his health, he took his

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own life. Dr. Replogle had practiced in Bryan and Evansport for nearly 35 years, and for the past 10 years had been health commissioner of Williams County. He was active in political and civic affairs, as well as in the Williams County Medical Society. He is survived by his widow, one son, and two step-daughters.

William L. Rhonehouse, M.D., Maumee; Homeopathic Medical School, University of Michigan, 1910; aged 46; died January 6 from a fractured skull received when his automobile was struck by an interurban car. Dr. Rhonehouse, son of a physician, was born in Maumee and received his early education at the old Toledo Central High School and Doane Academy, Granville. He attended Denison University before entering the University of Michigan where he served on the medical faculty following his graduation. Dr. Rhonehouse was a member of the Maumee board of education, and a former member of the village council. He is survived by his widow and two sons.

Sumner C. Sackett, M.D., Fremont; Cleveland College of Physicians and Surgeons, 1896; aged 65; member of the Ohio State Medical Association and the American Medical Association; died December 25 following a stroke of apoplexy. Dr. Sackett, a native of Putnam County, graduated in pharmacy at Ohio Northern University before entering medical school. After practicing in Milford Center for several years following his graduation from medical school, Dr. Sackett opened an office in Fremont in 1903. He is survived by his widow, one son, one daughter, one brother and one sister.

Leonard Walden, M.D., Dayton; Medical College of Ohio, Cincinnati, 1884; aged 72; died December 28. Dr. Walden, the son of the late Bishop John M. Walden of the Methodist Episcopal Church, had practiced medicine for more than 30 years in Bond Hill, Cincinnati, before retiring from active practice and moving to Dayton about 10 years ago. He is survived by one sister with whom he resided and three nieces.

Henry Edward York, M.D., Painesville; McGill University Faculty of Medicine, 1894; aged 65; died December 24. Following his graduation from McGill, Dr. York moved to Fairport residing there until 1911 when he moved to Painesville. He was for six years coroner of Lake County. Dr. York was physician for several railroads and during the World War was examining physician for the Lake County Draft Board. He was a Thirty-Second Degree Mason. Surviving are his widow, two daughters, four sons, one sister, and three brothers.



—At a recent organization meeting of the staff of St. Thomas Hospital, Akron, Dr. John E. Monnig was elected chief of staff; Dr. James G. Kramer, vice chief, and Drs. Daniel C. Brennan, Carl R. Steinke, and Edward C. Banker, member of the executive committee.

—Marie A. Wooders has resigned as superintendent of the school of nursing at the Springfield City Hospital. Miss Ursula Heileman will be in charge of the school until a successor to Miss Wooders is appointed.

—Finishing touches are being made on the new $2,000,000 Good Samaritan Hospital, Dayton, which is expected to be ready for occupancy about March 1.

—Dr. Philip T. Knies has been appointed to a residency in medicine and Dr. D. D. Deeds to a residency in surgery at the University Hospital, Columbus.

—Dr. G. O. Rowland was re-elected president of the staff of the Alliance City Hospital. Other officers re-elected were: Dr. N. W. Hole, vice president; Dr. H. L. Weaver, treasurer, and Dr. G. L. King, Jr., secretary.

—The following intern appointments for 1932

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have been announced by the board of trustees of General Hospital, Cincinnati: Richard D. Bryant, William Chambers, Phil Elliott, Joseph Filger, Thomas G. Folsom, Roy L. Tile, David Lerner, Carl M. Lippert, Edward McGrath, Esther C. Marting, Carl Minning, Donald R. Nelson, Carl J. Wolfe, R. F. Niehaus and Nelson W. Ryan, of the University of Cincinnati; Albert Reas Anneberg, Iowa; O. L. Bettag, Iowa; M. H. Book, Toronto; Robert C. Byrne, Rush; Hunt Cleveland, Vanderbilt; Corrin Hodgson, Minnesota; Carl A. Kunath, Harvard; Henry B. Lacey, Ohio State; Howard C. Lavender, Vanderbilt; M. H. Metz, Baylor; E. R. Muntz, Wisconsin; Robert H. Sykes, Washington; M. V. Teem, Emory; Helman C. Wasserman, Washington, and Abe Ravin, Colorado.

—Lorain County's new $425,000 tuberculosis sanatorium at Pleasant View is now in operation. It has a bed capacity of 76.

—Dr. Reed Cranmer has been elected president of the staff at the Ohio Valley Hospital, Steubenville. Dr. C. S. Sunseria was named vice president and Dr. M. H. Rosenblum, secretary-treasurer. Members of the executive committee are Drs. J. T. Miller, John Y. Bevan, F. R. Harrington, A. E. Weinstein, and Carl Goehring.

—Monnett Hospital, Bucyrus, heretofore a private institution, has been taken over by the city and will be operated as a municipal hospital until the completion of the city's new municipal hospital, now under construction.

—The following have been appointed to internships at the Good Samaritan Hospital, Cincinnati, starting July 1, 1932: Albert H. Gellenbeck, Jr., Henry C. Beekley, Joseph G. Crotty, Richard R. Marnell, Charles H. Moore and Edward O. Guerrant, of the University of Cincinnati; John A. McNamara and Edmund F. Ley, Loyola; Deane C. Hartman, St. Louis; Fred W. Rulander, Louisville, and Harry G. Thompson, Maryland.

—Dr. H. A. Springer has been appointed a member of the medical staff at Deaconess Hospital, Cincinnati.

—Excavating for Lima's new $500,000 Municipal Hospital has been started.

—Dr. Marion F. Stormont, Xenia, has been appointed assistant resident surgeon at St. Luke's Hospital, Cleveland.

—The following have been appointed to the staff at St. Mary's hospital, Cincinnati: Dr. Charles J. McDevitt, assistant attending urologist; Dr. Lowell F. X. Baurichter and Dr. Robert Pearle, assistant anesthetists.

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—Dr. F. A. Lawrence has been appointed medical adviser at the Gates Hospital for Crippled Children, Elyria.

—Bequests of the late Frank P. Berger to the City of Circleville for a municipal hospital were upheld by the common pleas court in a decision in the suit filed by Berger's heirs, charging the money had not been used in the time specified in the will.

—Dr. Harry M. Box has been re-elected president of the staff at Deaconess Hospital, Cincinnati. Dr. Charles E. Hauser was elected vice president and Dr. E. W. Enz, secretary-treasurer.

Annual meeting of the Northern Tri-State Medical Association, composed of physicians from Ohio, Indiana and Michigan, will be held in Toledo, April 1.

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PUBLIC HEALTH NOTES

—Dr. J. M. Higgins, who recently ended his thirtieth consecutive year as health commissioner of the City of Athens, has been reappointed to another two-year term by the City Board of Health. He also has been health commissioner of Athens County for the past 12 years.

—The Champaign County Board of Health has reappointed Dr. L. A. Woodburn health commissioner of the county.

—Dr. John L. Lavan, who was dismissed as city health commissioner of Toledo along with 125 other city officials and employes by Toledo's new mayor, Add Thatcher, has announced that he has accepted a similar position in Kalamazoo, Michigan.

—Dr. Clyde L. Vorhies, who has served as health commissioner of Cambridge for the past five years, has been reappointed for another 12-months term.

—Dr. F. M. Teeple, who resigned recently as coroner of Sandusky County, has been appointed county health commissioner, succeeding Dr. O. H. Thomas.

—Dr. Byron E. Neiswander, formerly chief of the division of industrial hygiene, State Department of Health, has been appointed health commissioner of Franklin County, succeeding Dr. H. L. Mitchell, resigned.

—Philip S. Steward, sanitary inspector and local registrar of vital statistics at Chillicothe since 1908, died at his home recently. Mr. Steward organized the vital statistics registration work in Chillicothe and was one of the veterans in public health work in Ohio.

—Dr. C. H. Beight has been appointed health commissioner of the City of Youngstown.

—Reappointment of Dr. C. J. Baldridge as health commissioner of the City of Hamilton has been announced by the city board of health.

The American Association for the Study of Goiter is again offering a $300 award for the best essay based upon original research work on any phase of goiter presented at the next annual meeting of the association to be held in Hamilton, Ontario, June 14-16. Competing manuscripts must be in English and in the hands of the corresponding secretary, J. R. Young, Rose Dispensary Building, Terre Haute, Indiana, on or before March 15.

A compilation of the essential Ohio statutes relating to the State Department of Public Welfare, benevolent, correctional and penal institutions, and kindred subjects, has been published in bulletin form (No. 32) by the State Department of Public Welfare for handy reference by those interested in the provisions of these laws.

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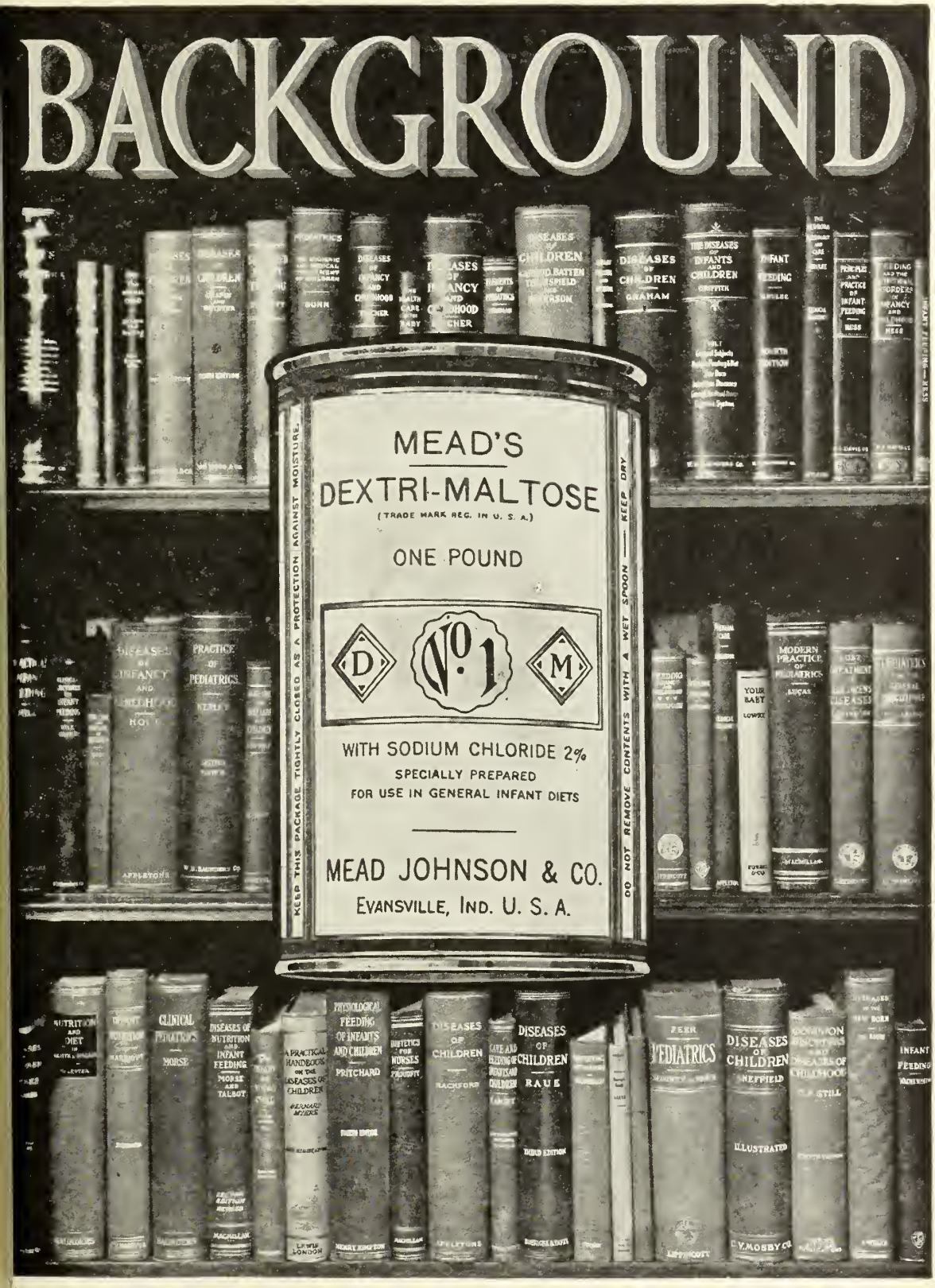
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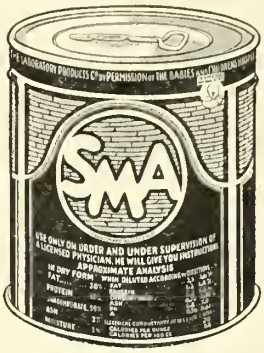
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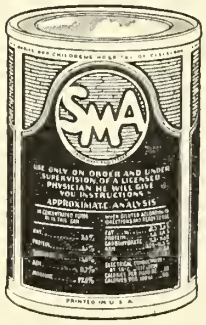
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Number - - - 3

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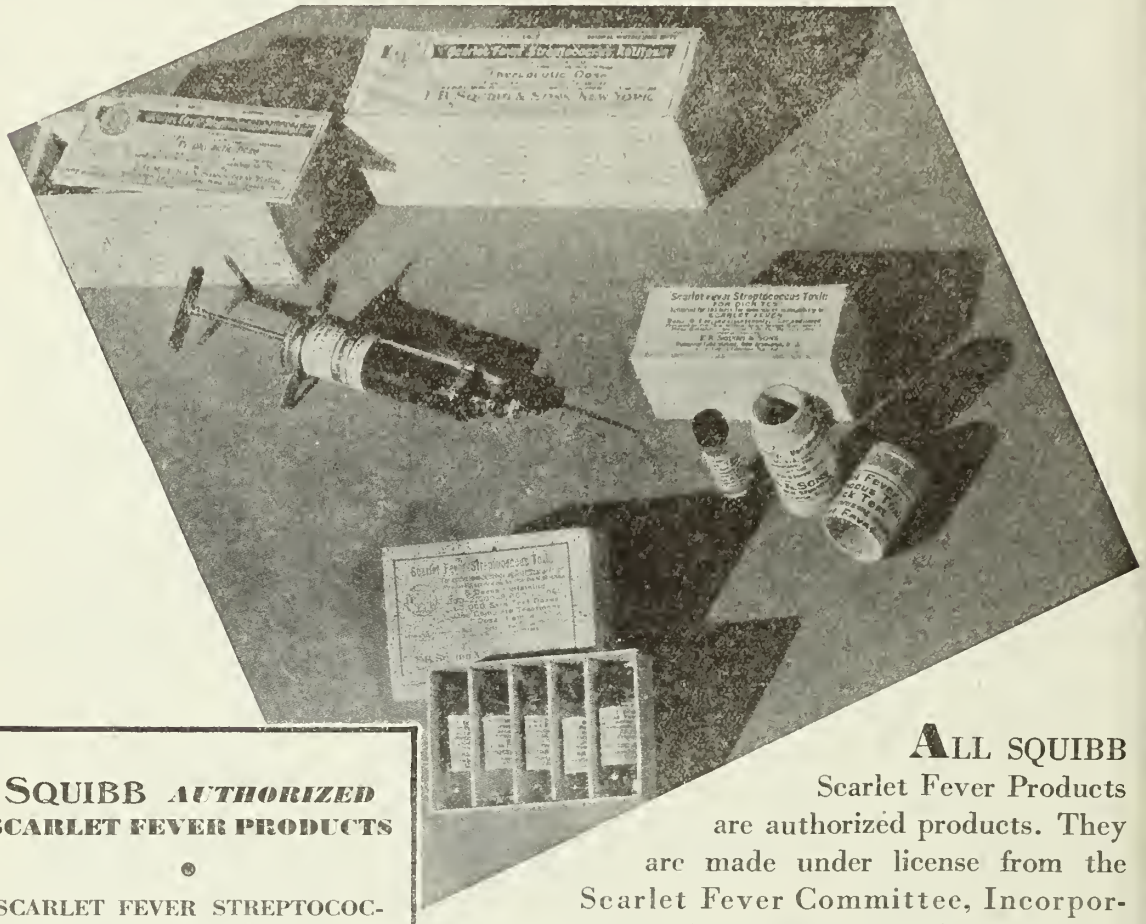
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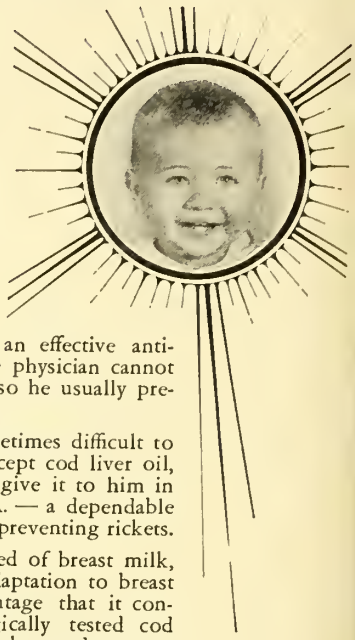
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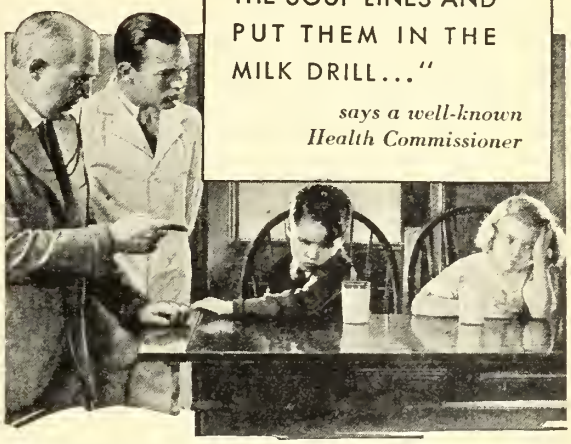
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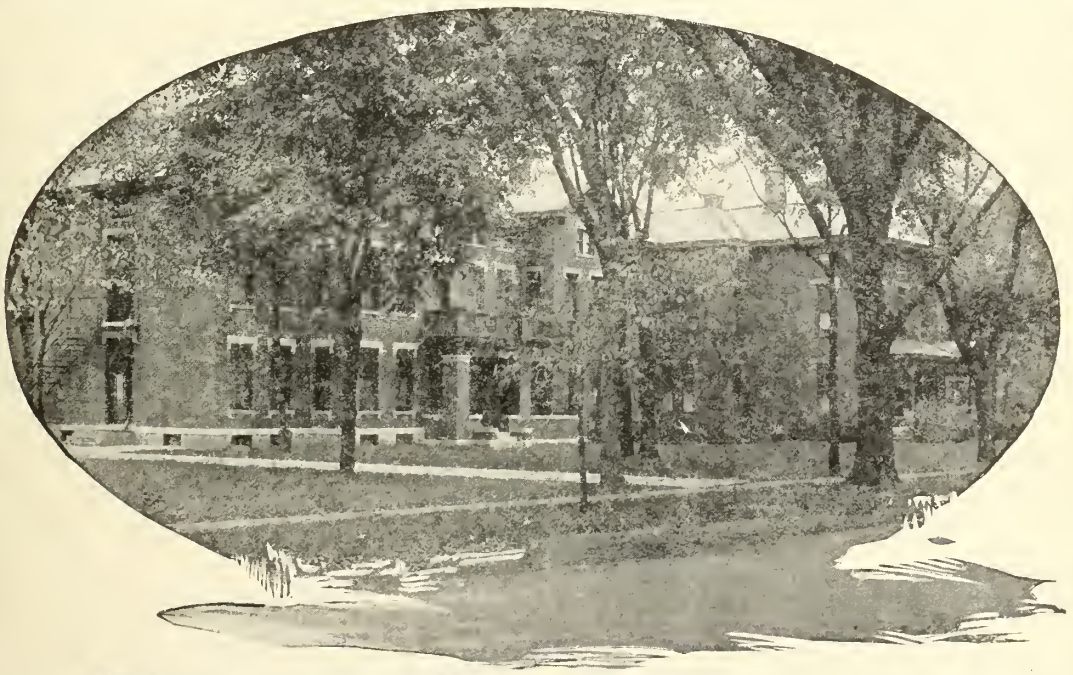
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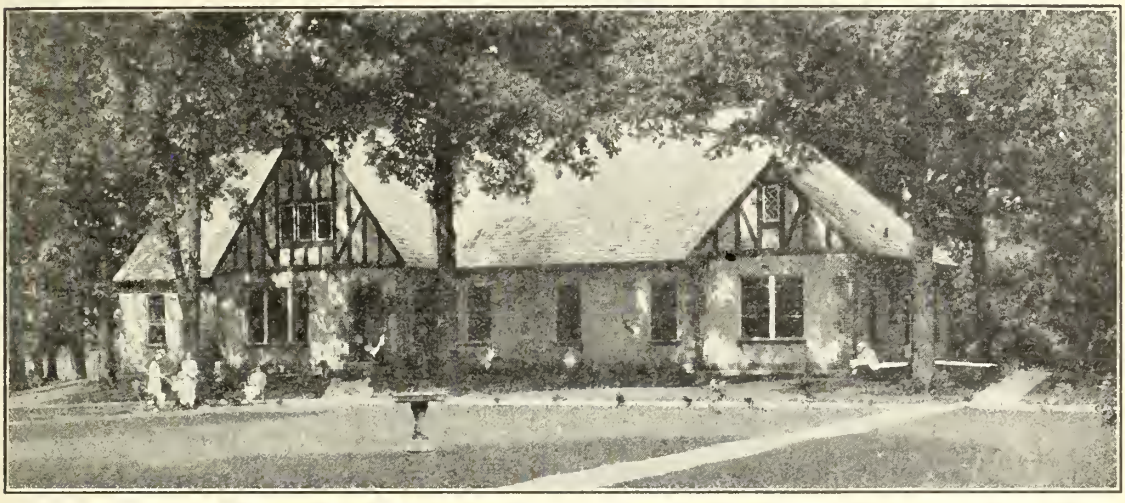
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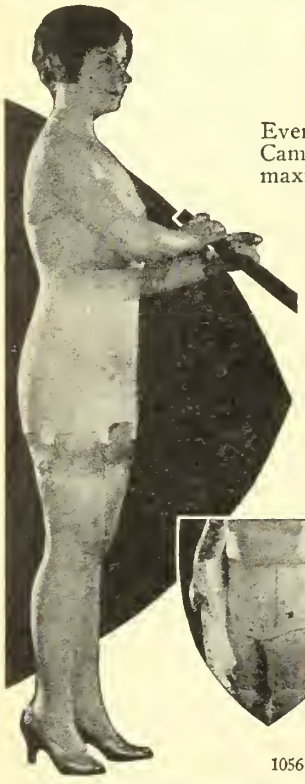
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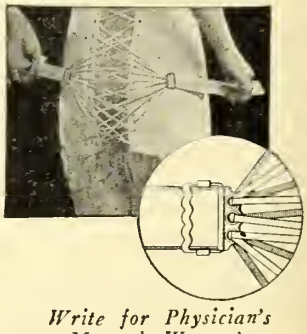
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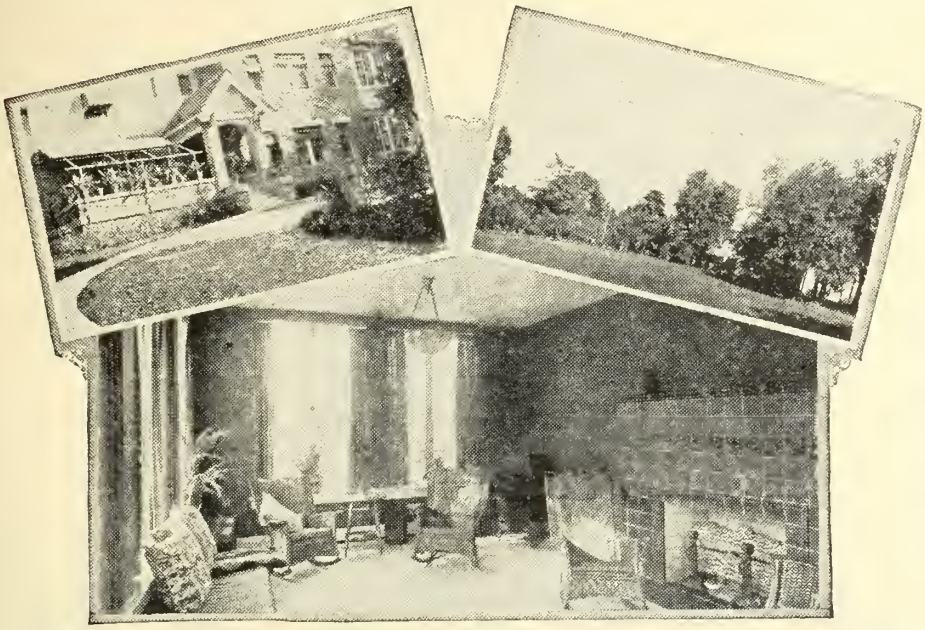
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For purely nervous cases, nutritional errors and convalescents.

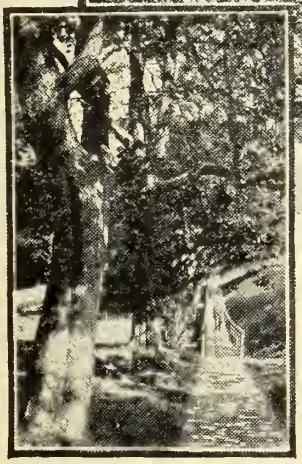
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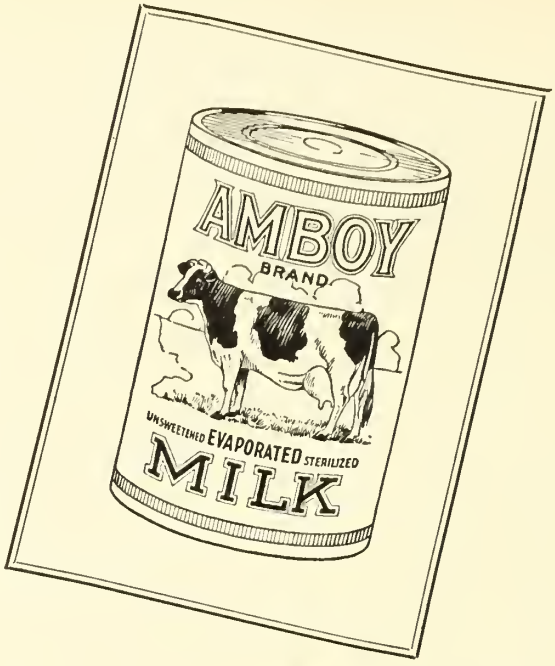




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NEGLECT IS YOUR HEALTH'S WORST ENEMY



Are YOU Guilty?

YOU probably are! . . . Your doctor cannot seek you out and offer you his help. The ethics of his profession forbid that.

All he can do is to wait for your summons.

He is prepared, not only to help those who are actually ill, but also to prevent illness in those who are apparently well.

Why call upon him NOW? Here are reasons:

1. Millions of men and women are well, but not so well as they might be. You may not actually be sick but at the same time you may not be enjoying buoyant health. An examination by your family doctor is the best possible way to get the utmost out of your good health possibilities.

2. Physically and psychologically, you are an *individual.* A health examination will enable your doctor to learn your constitution, temperament, and tendencies. If you should become ill, this knowledge will be of great help to him. The more he knows about you the more he can help you.

3. You probably have certain weak spots in your health-armor. Your doctor can find these spots and strengthen them *before* disease attacks you.

4. Disease germs are everywhere. You can't avoid contact with them. But your doctor can take certain steps to protect you against contagious diseases.

5. You may have a number of fears about your physical health which are real to you, but which your physician may prove actually baseless. Many of us make ourselves ill by useless worry.

Neglect is your health's worst enemy. The most important step in the battle is to go to your doctor before he has to come to you.

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HAY FEVER

An Advertising Statement

HAY FEVER, as it occurs throughout the United States, is actually *perennial* rather than *seasonal*, in character.

Because in the Southwest—Bermuda grass, for instance, continues to flower until December when the mountain cedar, of many victims, starts to shed its pollen in Northern Texas and so continues into February. At that time, elsewhere in the South, the oak, birch, pecan, hickory and other trees begin to contribute their respective quotas of atmospheric pollen.

But, nevertheless, hay fever in the Northern States at least, is in fact seasonal in character and of three types, viz.:

TREE HAY FEVER—*March, April and May*
GRASS HAY FEVER—*May, June and July*
WEED HAY FEVER — *August to Frost*

And this last, the late summer type, is usually the most serious and difficult to treat as partly due to the greater diversity of late summer pollens as regionally dispersed.

With the above before us, as to the several types of regional and seasonal hay fever, it is important to emphasize that Arlco-Pollen Extracts *for diagnosis and treatment* cover adequately and accurately all sections and all seasons—North, East, South and West.

FOR DIAGNOSIS *each pollen is supplied in individual extract only.*

FOR TREATMENT *each pollen is supplied in individual treatment set.*

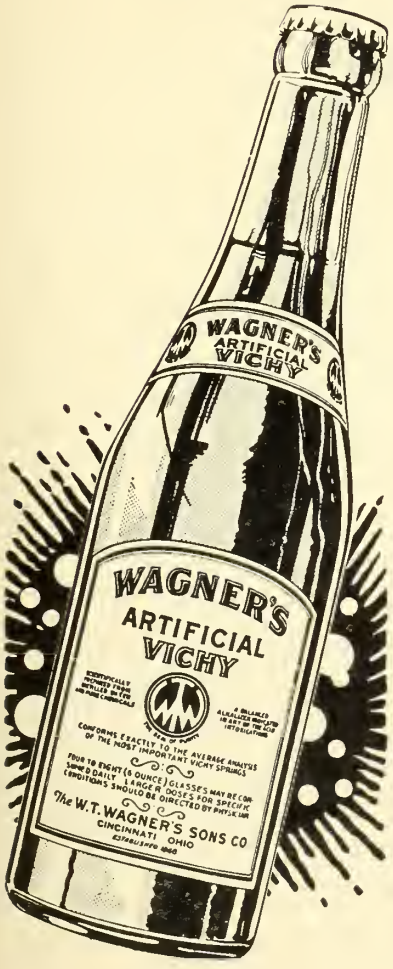
ALSO FOR TREATMENT we have a few logically conceived and scientifically justified mixtures of biologically related and simultaneously pollinating plants. Hence, in these mixtures the several pollens are mutually helpful in building the desired group tolerance.

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ENZYMOL resolves necrotic tissue, exerts a reparative action, dissipates foul odors; a physiological, enzymic surface action. It does not invade healthy tissue; does not damage the skin.

The hydrolyzed material is readily removable by irrigation.

These are simply notes of clinical application during many years:

Abscess cavities
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Diabetic gangrene
After removal of tonsils
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NEW YORK

PUBLIC HEALTH — SOCIAL WELFARE MEDICAL ECONOMICS and ORGANIZATION PROBLEMS

With Editorial Comment by D.K.M.

Bright Prospects For Annual Meeting

Preliminary arrangements for the Eighty-Sixth Annual Meeting of the Ohio State Medical Association, to be held May 3 and 4 at the Dayton-Biltmore and Miami hotels, have been completed.

Under the direction of the Council Program Committee, one of the most interesting programs ever arranged for an annual meeting of the State Association has been formulated.

Officers of the various scientific sections have made a special effort to make their respective sectional programs varied in character and of general interest, while the Program Committee in arranging for a symposium to be presented by the three Class A medical schools in Ohio at one of the general sessions has made a unique contribution to the annual meeting program.

The entire official program for the two-days session will be published in the April issue of *The Journal.*

The special attention of members of the State Association is called to the list of Dayton hotels published elsewhere in this issue of *The Journal.* Physicians who are contemplating attending the Annual Meeting should make hotel reservations as promptly as possible to insure accommodations at, or conveniently near, the annual meeting hotels—the Biltmore, the headquarters hotel, and the Miami.

One of the innovations of this year's annual meeting will be the staging of a Scientific Exhibit. The Scientific Exhibit held annually by the American Medical Association has always proved one of chief attractions of those meetings.

Additional information on the Scientific Exhibit will be found in an article appearing elsewhere in this issue of *The Journal.*

As pointed out in last month's issue of *The Journal* and repeated here for emphasis, every Ohio physician who can possibly do so should avail himself of the opportunity of attending the Dayton meeting. The present economic and social situation makes it imperative that the medical profession as an organized group keep informed on present-day social and economic trends, as well as on medical and health questions. The annual meeting offers the chance for a discussion of these questions and for an exchange of ideas and views. It serves as a clearing house for information on the way situations and problems are being handled in the various communities and it is a forceful factor in stimulating active interest and cooperation among the profession generally in the activities, programs and problems of the State Association. Also, it is a concentrated postgraduate course on health and medical questions, where new information on scientific and preventive medicine is analyzed, new technics explained, and additional data and information for the benefit of the profession as a whole presented.

Problems Incidental to Depression

Although there is little evidence so far that the end of the current economic and social situation is in the near offing, far-sighted students of economic and sociologic history are beginning to look ahead.

Their attitude is that the causes, direct and indirect, of present unsettled conditions have been pretty well established and digested by this time; that most of the lessons which should be learned are perfectly obvious, and that little is to be gained by hashing and rehashing the information which has already been obtained on the subject.

However, many of those who have decided that the best policy right now is to look ahead are becoming somewhat alarmed over the possibilities of the future, especially from the standpoint of whether a lot of the principles of government, economics and social relations which have become fundamental in the American creed will be able to stand the strain to which they have been put.

As pointed out editorially by the *Cincinnati Enquirer*:

"The greatest danger that the country faces just now is not depressing itself, however challenging its problems are. On the contrary, the real threat is that we may adopt a series of palliative schemes which will break down the individual initiative on which our national economy is founded. This is true in the states and especially in the Federal Government.

"To meet the temporary problems of straitened business and unemployment, many groups are advocating hasty measures of socialization, not only in the form of social insurance but through subsidies to many industries. Some of these panaceas are enacted or are being considered seriously. Others are merely a potential threat. All of them, taken as a whole, could change completely the nature of our economic system and the very nature of our people.

"Because they possess the taxing power governments tend to absorb more and more functions,

once performed by the individual, the family or the private corporation. Unless responsible groups maintain a continuing struggle against this growth of public functions we soon shall find the Nation in the futile impasse of Germany and Great Britain where citizens are weighed down by tax burdens and the Governments are strangled in their effort to carry on a maze of duties not properly theirs. * * * We should not be stampeded into hasty concentration of power in government. The consequences for our general welfare would be disastrous."

Many of the panaceas and palliatives which have already been suggested are being justified by their proponents under the "welfare" clause of the Constitution which has been interpreted by the courts to be broad enough to include about all the social service enterprises so far conceived.

To what extremes the social service undertakings of any government may be carried is splendidly illustrated in the case of Great Britain.

Not long ago the *Manchester Guardian Weekly*, quoting from a British governmental document, presented the following figures in pounds of the annual cost of "public social service in England, Wales and Scotland":

Unemployment	53,296,000
Health insurance	38,570,000
Widows', orphans' and old-age contributory pensions	27,816,000
Old-age pensions	37,290,000
War pensions Acts and Ministry of Pensions Acts	52,658,000
Education	108,528,563
Reformatory and Industrial Schools	698,565
Hospitals and treatment of disease	8,757,000
Maternity and child welfare	2,661,000
Housing	35,598,000
Relief for the poor	46,329,904
Unemployed Workmen Act	44,000
Lunacy and mental deficiency	5,271,000
Total	417,618,032

Little wonder that England, as one writer comments, "has tried socialization and dumped herself nearly into the ditch".

With sufficient examples before them, it is high time that the administrative and legislative branches of state and federal governments in this country not only refuse to have anything to do with schemes adding to or expanding the present paternalistic activities of government but also begin eliminating many of the socialized functions which are already eating up a goodly share of the public revenue.

Relative to emotional pleas for enactment of legislative panaceas and socialized make-shifts to meet temporary conditions, it would be well for those charged with the responsibility of keeping the nation on an even keel to heed the following advice given on an appropriate occasion by the late President Hadley of Yale:

"While the men of emotion may sometimes be right and the men of reason wrong, the chances in matters of legislation are most decidedly the other way. It is safe to say that the harm which has been done by laws based on unemotional reasoning is but a drop in the bucket compared with that which has been done by laws based on unreasoning emotion. * * * Nothing can be more fatal to that efficiency of public opinion on which all good government rests than the habit of fixing our eyes on immediate consequences instead of permanent causes, or of giving to the emotions of a body of witnesses the dignity of the deliberate judgment of a court."

Broadening of General Practice

Not infrequently, the pessimistic prediction is voiced that the family physician is doomed and that the time is just around the corner when the general practitioner of medicine will have passed from the picture, to be supplanted by the specialist or the service offered by the group clinic system.

Those making this forecast no doubt feel justified in their contentions as there is some evidence, to be sure, to support their claims.

On the other hand, there is ample evidence to the contrary, which indicates that the role the family physician plays in the practice of medicine and medical service is growing more important as time passes, especially with incipient conditions, health examinations and preventive medicine.

For example, we may consider the part which the family physician is now taking in the care and treatment of those suffering from tuberculosis.

Not so many years ago, the first step of a patient in the fight against tuberculosis consisted of packing a trunk and boarding a fast train for some far corner of the continent to obtain the benefits of a different climate and take the treatments given by some highly advertised sanatorium.

Now, climate is no longer considered the essential factor in treating tuberculosis. Proper medical and nursing care has supplanted the "climate" cure as the primary factor.

The following excerpts from a recent bulletin issued by the United States Public Health Service are significant and reveal the modern conception in combating the disease:

"The home climate, even if it is the worst in the world, is best for the tuberculosis sufferer if proper medical and nursing care is available there but lacking elsewhere. Good medical care can now usually be found near at home, although twenty years ago one had to go to a resort to find a tuberculosis specialist. Skillful doctors and nurses and good sanatoria can be found in almost every state. Many persons have lost their lives by going to distant places, reputed to cure tuberculosis, where they camped out or lived in a boarding house or sought a light job, and they might have recovered if the money had been invested in proper treatment near at home.

"The family doctor is tempted to advise his tuberculosis patients to go away, often against his better judgment. It is no longer necessary to exile a patient to obtain proper treatment."

The announcement points out the progress that has been made by the general practitioner in the fight against tuberculosis and summarizes the benefits obtained by the patient by remaining at home under the care of his family physician, among his relatives and friends and minus the additional expense of living at some resort or in some section of the country where the costs of proper living conditions are relatively higher than in his home community.

In other words, the Public Health Service believes that in the final analysis proper medical and nursing care are the prime factors in defeating tuberculosis.

The family physician's part in the continuous war on tuberculosis is today more prominent than ever before. It is up to him to supply the necessary and proper care and treatment. It is up to him to counsel his patients against falling for the alluring propaganda of distant institutions or resorts which offer no better, if as good, care and supervision than may be obtained near at home.

Business Efficiency In Hospitals

Judging from their financial statements for the year 1931, many Ohio hospitals have demonstrated the value of economy and efficiency in management in meeting financial emergencies.

A check of the records of hospitals picked at random reveals that some Ohio hospitals during the past year actually ended the year with a surplus—not large in most cases, but a surplus nevertheless. Others ended the year with a deficit considerably smaller than that reported for 1930.

In practically every case where the financial condition of the hospital was reported as satisfactory, credit for the accomplishment was given to efficient management of the business affairs of the institution leading to economy in operation without curtailing necessary and essential services for the benefit of patients.

While this does not necessarily show that many hospitals are not confronted with serious financial problems, it does indicate that economies can be effected in emergencies and that careful handling of the affairs of the institution pays in dollars and cents.

As usual, the biggest drain on the financial resources of most hospitals has been caused by the large amount of free service rendered, in some cases not to persons actually classified as indigents.

One example is the big loss sustained by hospitals in caring for victims of automobile accidents. A recent statement issued by the Ohio Hospital Association shows that 120 Ohio hospitals, representing 85 per cent of the hospital bed capacity of the state, during 1930 handled 21,056 automobile accident cases in their emergency departments and that 8,889 of these were subsequently admitted to the hospital. The total cost of caring for these patients, who received 113,811 days treatment, was estimated as $634,-391.58, of which $295,861.29 was collected, leaving a total of $338,498.29 in outstanding accounts, most of which never will be collected. The report estimates that the total loss of all hospitals in the state from this cause would approximate $395,000.

Despite this difficult problem, and one which hospitals are making desperate attempts to solve in some way, it appears that the current economic depression has furnished valuable experience to hospitals in their effort to solve their economic problems. That is, many hospitals have learned a lot about how to go about balancing their budgets, effecting economy where it will hurt the least, and how to eliminate in painless fashion some of the desirable, but in the final analysis, unnecessary services which have grown up through popular demand. Practically all this has been accomplished, too, without lowering the standards of hospital service.

Many experts in business and industrial lines undoubtedly could profit by heeding the lesson which has been learned by many hospital administrators. It is to be expected that hospitals will continue even after the financial crisis has ended with their present policy of keeping their financial affairs on a sound, practical, business basis.

Civilization In Ratio To Science

Dr. Charles Singer in an address before the International Congress of the History of Science declared that "the rise of science was the most important event in human history since the fall of the Roman Empire, and a textbook of history which did not say so did not teach the truth".

One journal, commenting on Dr. Singer's statement editorially, agrees that science must occupy a lofty position in historical reviews, however, it warns against the temptation "to view the past as a series of methodical approaches toward the future success of a regular service of liners between the earth and Mars".

"There are other events, achievements and advances in thinking, manifestations as quiet as those which proved the law of gravity, which have a significance even greater in the progress of the human race, "the writer continues." The rise of a great social or religious movement may

carry far more import than a war, or even an invention. We must ask the historian to keep this fact in view and not merely to substitute conquests in the laboratory for conquests in the battle field."

It is true that the historian must be on guard constantly against overemphasizing the spectacular but less important events at the expense of the less dazzling but vitally significant happenings.

Take the progress and advancement of the science of medicine, for example.

There is about medicine nothing that is spectacular. There is comparatively little of the sensational which marks the conduct of a great social or political movement; the clash of armies; the rise or fall of governments; the conquests of the adventurer, etc., in medical research and medical practice.

On the other hand, it is interesting to cogitate as to just what the status of civilization would be today had it not been for the conquests of medical scientists and the application of the fruits of their labors by the medical practitioners, past and present.

There is little doubt but what civilization has progressed in direct ratio to advancement in the science of medicine. It is the one thing that has a direct bearing on all the achievements commonly credited with making history.

No textbook of history is complete in any sense of the word unless it places justifiable emphasis on the part which medicine has had and will continue to play in the course of human events and in the advancement of civilization.

Clinical and Laboratory Tests

"Mass production is all right for industry, but for the treatment of disease it is not so good," Dr. Erwin von Graff, professor of gynecology at the University of Vienna, was recently quoted in a Kansas City newspaper.

"The human body cannot be taken apart to be studied like a machine," the eminent professor from the European center that has adventured into many realms of social medicine and socialistic enterprises generally, is reported as having said: "The body is a thing to be studied first and taken apart afterward, if the taking apart is necessary."

"Your laboratories are incomparably equipped, but there is an overestimation of the value of laboratory work in this country. It is being substituted for brain work and personal experience.

"The American ideal is the group clinic, where each part of the body is examined by a different man who charts it and describes it. These charts and papers are taken to another man who never has seen the patient, and from the charts he attempts to diagnose the disease.

"That method leaves out the personality of the patient; what the personality has; its nature and tendencies and mental habits. The laboratory can determine that two patients with pneumonia yield exactly the same results in the laboratory tests, but it can't determine that one of those patients will die and the other will recover. The good physician knows which one will die and which one will recover, because he has studied the patients as well as their laboratory tests. He knows also what he must do, besides combat the disease, to prevent death. One patient has the spirit to get well. The other has not. It is a psychosis to be diagnosed and treated along with the treatment of the disease."

Commending the statement of the Vienna physician, the Cincinnati *Journal of Medicine* declares that he has reemphasized the frequently repeated advice that the physician "must always treat the patient, not the disease."

"The old family physician was useful to his clientele, not only on account of his knowledge of medicine but his knowledge of the people with whom he had to deal," that *Journal* declared.

"He knew their heredity, their environment, and their attitude toward life. This not only enabled him to treat his patients more wisely, but to be more accurate in his judgment as to the course the illness would run and its final termination.

"One of the advantages in not being connected with any group in the practice of medicine is that one can select whatever consultant he thinks best suited to take care of the individual he wishes to refer. There may be two men of equal ability in the same line of work, but their personalities may differ so much that while one might inspire confidence in the patient, the other would inspire only antagonism. With another patient the second man mentioned might be able to absolutely control the patient while the first could do nothing of the kind."

The laboratory has justified itself and has won for itself a distinct and permanent place in the practice of medicine. It has become an indispensable aid in the fight against disease. Much has been accomplished through and by it, and much more will be accomplished.

Clinical training, which means quickened observation, accumulated experience, thorough academic schooling and experience in practice, cultivated memory and the power of deductive reasoning, is an indispensable factor in medical practice. Laboratory medicine is likewise an indispensable factor.

To *supplement* clinical medicine with laboratory medicine, or vice versa, is undoubtedly correct pratice by the modern physician; to *substitute* one for the other is a serious mistake.

The Aluminum Hydroxide Treatment of Peptic Ulcer

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THE basis for the study of aluminum hydroxide in the treatment of peptic ulcer is the observation that many gastro-intestinal conditions in infancy are benefited by the use of kaolin. This suggests that aluminum compounds might be serviceable in the treatment of peptic ulcer in adults. The literature on the subject is scanty. However, French gastro-enterologists have used aluminum silicate as one of the ingredients in prescriptions for ulcer of the stomach. In America, Burrill Crohn in April, 1929, in the *Journal of Laboratory and Clinical Medicine* reported on his experience in the use of colloidal aluminum hydroxide as a gastric antacid.

In December, 1930, a paper was given before the experimental section of Medicine of the Cleveland Academy of Medicine by I. H. Einsel, M.D., J. W. Mull, Ph.D., and E. Muntwyler, Ph.D., on an intensive study of six cases of duodenal ulcer by the use of aluminum hydroxide. There were twenty-five cases studied. Six were studied intensively. The original six cases were hospitalized and were given a diet of the modified Sippy type. There were observations on the acid-base balance of the plasma and on the aluminum content in the blood and urine. The urine was examined for albumin, change in reaction, casts, and red and white blood cells during time of treatment. In no case was there found any pathological change in the urine or blood. The acid-base balance of the plasma showed no change after a daily intake of 16 to 32 grams of aluminum hydroxide. There is an immediate very small increase in the aluminum content of the blood and the urine following the administration of aluminum hydroxide, but paradoxically this falls again after a short time even with an increased dosage to almost a pretreatment level.

In the treatment of peptic ulcer by the Sippy routine a certain per cent of the patients will show an alkalosis. Sippy observed this fact. Hardt and Rivers in 1923 were the first to prove that the soluble alkali such as sodium bicarbonate used in the Sippy treatment gave an alkalosis. Later, V. C. Myers emphasized the clinical syndrome of alkalosis. It is characterized by headache, dizziness, vomiting, etc., beginning about the third day of treatment, and under increasing dosage, eventually, by edema of the extremities, convulsions and death. This certainly is a disadvantage in the standard treatment of peptic ulcer. Any method which would preclude the possibility of alkalosis would be a material advance in treatment. From our previous reported experimental results alkalosis is not produced by aluminum hydroxide.

The first twenty-five patients were treated with aluminum hydroxide of Merck's and Mallincrodt's brand.

Usual Routine:—One-half hour after eating, the patients were given four grams of aluminum hydroxide powder in water. The number of feedings was six a day. The diet was that of a modified Sippy with elimination of all meats and meat soups. Patients were advised against the use of alcohol in any form, tobacco and fried foods.

It might be of value to review the action of aluminum hydroxide powder in specific cases. All cases in this report gave a classical history of duodenal ulcer with positive *X*-ray findings by the hospital radiologist.

Case I. Male, age 54, with characteristic pain every few months for twenty-five years, has been under treatment with aluminum hydroxide powder for one year without recurrence of pain or vomiting. The diet was of the modified Sippy type—six feedings daily.

Case II. Woman, age 30, with typical ulcer pains, and *X*-ray deformity, has been observed for eight months with no symptoms during this period. Previously she had had intermittent pains for nine years and could secure no relief.

Case III. Man, age 58, symptoms for sixteen years, was tested for six months, with modified Sippy diet with calcium carbonate and magnesium oxide without definite relief. He has now been on aluminum hydroxide in the usual dosage for nine months and has been completely relieved.

The last three cases showed by gastric analysis a marked hyperacidity to a maximum of 80 free hydrochloric acid and total acid of 130.

Since these patients showed marked relief from the medication it was assumed that the aluminum hydroxide powder had the power of neutralizing the acidity of the stomach. But to our surprise the neutralizing power of aluminum hydroxide powder is comparatively slight to N/10 HCl. Consequently the exact mechanism of this symptomatic relief is not clear. In this series, we studied twenty-five cases. There were twenty-two male patients and three females with a diagnosis of duodenal ulcer. The average length of treatment was twelve months, several seventeen to twenty-one months. Twenty-two cases became quite symptom free, two cases were slightly improved, one unimproved. This case had the complication of drug addiction.

It was thought that if a preparation of aluminum hydroxide of a colloidal nature could be made it might be more serviceable than the

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aluminum hydroxide powder. So after months of experimental work, a colloidal cream preparation was made. The method of preparation will be published later.

The aluminum hydroxide cream is an amphoteric substance with a slight astringent but not unpleasant taste. It gives no gastric irritation or constipation. Patients do not object to taking it. Titration shows it to be neutral to neutral red, yet it shows extraordinary properties of neutralizing free HCl. Four cubic centimeters will neutralize or absorb 40 cubic centimeters of N/10 HCl. With this property of fixing large quantities of free HCl, we have the advantage of alkaline therapy without its disadvantages.

The management of the cases on the aluminum hydroxide cream was the same as in the cases on the powder, the diet being of the convalescent Sippy type, with six feedings a day. The cream was given in 4 cubic centimeter doses in one ounce of water one-half hour after each feeding.

The symptomatic relief in this series of cases was remarkable. Within a few days, all burning, nausea, and pain disappeared. The feedings could be taken without distress and the weight gradually increased.

Two additional cases may be cited. A woman, age 38, who had severe ulcer symptoms for four years, was treated with aluminum hydroxide cream. This case is of especial interest because she had been treated with the old alkaline therapy for a long period of time with little improvement. The pain was not relieved, the soreness and tenderness remained. After aluminum hydroxide cream all these symptoms have disappeared. She has now been under treatment for five months. This case was a chronic duodenal ulcer of four years duration.

The second case was that of a young man 22 years of age who had pain of six months duration. The history and *X*-ray findings suggested that the lesion was that of an acute uncontrolled duodenal ulcer. His alcoholic test meal showed a moderate hyperacidity, slightly higher than the first case. He has had complete symptomatic relief and is rapidly gaining in weight.

So far, we have treated thirteen cases of duodenal ulcer for an average length of time of five months. They all responded promptly and have had complete symptomatic relief. There have been no failures in this small series of aluminum hydroxide cream cases. There have been no idiosyncrasies to the drug, no vomiting, or toxic symptoms or complaints or evidence of gastric intolerance.

An attempt was made to compare the neutralizing power of aluminum hydroxide powder and cream with sodium bicarbonate, magnesium oxide, bismuth subcarbonate—in the stomach of a patient, under clinical conditions. One-half dram of aluminum hydroxide was given at hourly intervals from 6:30 to 10:30 A. M. and an Ewald test meal given at 8:45 A. M. Fractional specimens were taken from 9 to 11 A. M. Similar tests were made with 10 grains of each of the three alkalies. In brief, the results indicated that the aluminum hydroxide powder had practically no neutralizing power just as shown by direct titration, but the aluminum hydroxide cream produced a great and a more prolonged neutralization in the several gastric fractions than any of the other alkalies—sodium bicarbonate, magnesium oxide, or calcium carbonate.

We believe, therefore, that aluminum hydroxide in proper form, has possibilities of definite usefulness in the treatment of peptic ulcer and hyperacid states.

SUMMARY OF RESULTS

1. Aluminum hydroxide is useful in the treatment of peptic ulcer and is free from the disadvantages of absorbable alkalies and the danger of alkalosis.

2. Aluminum hydroxide powder is chemically neutral by titration with N/10 HCl and has little neutralizing power in the gastric secretion. A gelatinous aluminum hydroxide cream will neutralize 10 times its volume of N/10 HCl and reduce gastric acidity better than free alkali.

3. Blood analysis shows practically no absorption of aluminum hydroxide in 32 gram daily dosage and no alteration of the acid-base balance. There is no evidence of toxic action upon kidneys or other organs.

4. Symptomatic relief was surprisingly prompt and continuous in 92 per cent of 38 *X*-ray positive duodenal ulcer cases.

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The Management of Bladder Tumors

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THE management of bladder tumors is a less distressing subject to discuss today than was the case some years ago. The use of the cystoscope has enabled us to view the tumor in its surroundings and thus to make a clinical diagnosis, and for purposes of treatment it is widely agreed that this diagnosis is more reliable than that made by the pathologist from study of the cells, (Frontz, Lowner, Galbraith, etc.) "There is," says Keyes, "a clinical malignancy the degrees of which do not run quite parallel to those of cellular malignancy." This clinical malignancy is determined by the amenability of the lesion to such treatment as we have to offer. "The clinical malignancy of bladder tumors," he adds, "has been rapidly diminishing through the last twenty years." This more hopeful outlook is owing mainly to the introduction into urologic practice of fulguration with the high frequency current and, where cancer is concerned, to the employment of radium.

The "benign" papilloma used to be benign only to the pathologist. To the patient it meant death —more retarded than from cancer, but just as inevitable. Today that is no longer true. Is the situation being improved as regards cancer? To quote again from Keyes: "The specter of malignancy is fading." But he modifies this statement so that it refers mainly to the more superficial and localized tumors of the bladder and adds that the infiltrating growths are perhaps as malignant as ever they were.

This, then, is where we stand today: The benign papilloma we have made benign in fact. We have achieved some real progress with noninfiltrating carcinomas; i. e., we have reduced the degree of their clinical malignancy so that the bearer of such a tumor today is in a better position than was the bearer of a benign papilloma twenty years ago. In face of infiltrating carcinoma, our optimism receives a check; but here, too, our experience does not leave us without hope. This information should be passed on to the general profession, as Bransford Lewis recently observed, and they should be made to understand that cases of bladder cancer are not hopeless or cheerless or without promise, which is very different from the situation of former times with the old methods with one hundred per cent mortality.

The tendency to get away from an histologic classification made on inadequate data and to admit the clinical standpoint in the grading of the tumor to be treated has had its share in improving results. Much of the confusion existing in the past as to the treatment appropriate for a given tumor was owing to a classification based on histologic study of fragments removed through the cystoscope. Such fragments could give a misleading idea of the actual condition of the tumor in respect to malignancy. While no one would doubt Broders' assertion: "A neoplasm can accomplish only what its cells can accomplish," or that "a tumor may be papillary or firm and of a low degree of malignancy, or it may be flat or elevated and of a high degree of malignancy, or flat or elevated and of a low degree of malignancy," still, other factors than cellular malignancy play a part in the opportunities for successful eradication that a given tumor offers.

A wide variety of tumors have been found in the bladder, and the reports that appear from time to time in the literature of fibromas, leiomyomas, rhabdomyomas, myxomas, adenomas, sarcomas, etc., are interesting from a pathological standpoint and because of the natural human interest in the unusual. But from 90 to 95 per cent of bladder tumors are papillomas and carcinomas, so that our practical concern is with these growths.

The cystoscopic picture of the benign papilloma, which growth should be regarded as being potentially malignant, has been described by Galbraith as resembling a piece of semi-translucent sea-weed anchored to the bladder mucosa by a slender stalk. The fronds are long and free. It is the concensus of American and European opinion that tumors of this type are fully amenable to fulguration alone or to fulguration and radium. In most cases the treatment may be endovesical, the fulguration being given through the cystoscope and the radium emanation (if applied) being carried along the same route and buried in the tissue at the base of the tumor, enclosed in gold capillary tubes, or "seeds." When the tumors are multiple, the seances are continued over as long a period as is needed, with a fortnight's interval between. Local anesthesia may be used, not ether or ethylene because of the danger of explosion. The patient is not necessarily hospitalized. Frontz uses surface radium treatment as a preliminary to fulguration in the benign papillomas that prove resistant. If the papilloma is situated so as to be too difficult of access to cystoscopic fulguration, or if it is too large to be suitable for this method, or if it does not respond promptly, suprapubic cystotomy should be done and the fulguration then applied.

Young reports thirty cases of benign papilloma treated successfully by fulguration alone. Scott

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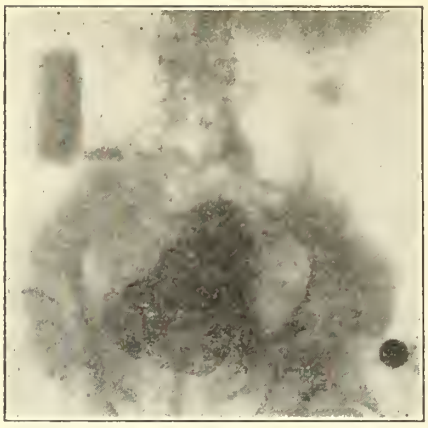


Figure 1. Cystogram, showing bladder irregularity and distortion due to malignant hypertrophy of prostate gland associated with cancer of bladder at the base.

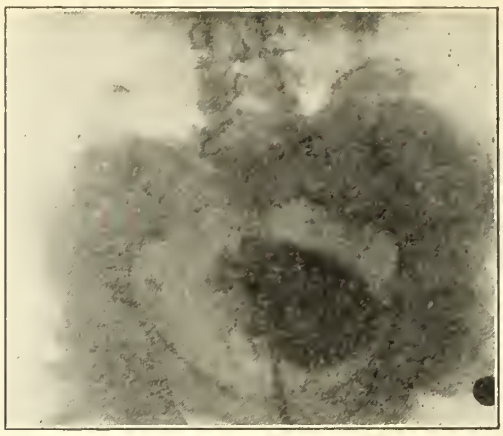


Figure 2. Cystogram, advanced inoperable infiltrating cancer of bladder involving the whole bladder neck region, left side of wall and left ureter. Note marked filling defect and irregularity in the contour and outline of the bladder.

and McKay traced forty patients who had been treated by fulguration alone. The periods of observation were up to nine years; not one had died of tumor. In two instances the growth recurred but was again destroyed by the same method. These authors found that while benign papillomas always respond to fulguration alone, they often disappear more rapidly when cystoscopic applications of radium are used in addition to fulguration.

In my own material of thirty-four cases of bladder tumor seen in the last three years and seven months, there were eight cases of benign papilloma. I used cystoscopic fulguration alone in these cases. All these patients were well when last seen. In five the periods of observation are from seventeen months to three and a half years. There have been no recurrences. The ages of these eight patients covered a wide range—from eighteen to seventy-five years and all except one of the decades between were represented. Five of the patients were women. In one of the latter, the tumor, which was elongated and occupied the roof of the bladder neck, served as a ball-valve at the internal vesical sphincter and had caused acute retention on three occasions. De Berne-Lagarde recently reported a leiomyoma of the bladder, 6 cm. long and inserted close to the neck posteriorly, which had resulted in complete retention through engagement of the tumor in the urethra.

The management of malignant tumors of the bladder offers difficult problems and there is not the same unanimity on the subject. Here the prognosis and largely the method of treatment depends on the presence and on the amount of infiltration. These tumors are frequently of a low degree of malignancy and do not metastasize early. If we could get these cases early, while infiltration was minimal, they ought to yield very good results. But we see them first, frequently, after hematuria has been present, off and on, for months or years, and hematuria itself is a late symptom. In six, or 23 per cent, of the twenty-six cases of malignant tumor of the bladder in my series, symptoms had been present for four years or longer, in one case for ten years, before I saw the patient. A further difficulty in getting the patient really early is that the growth may reach considerable development before any symptoms appear. I saw one of my patients, a man of seventy, the day after his first attack of hematuria. He asserted that he had had no previous urinary symptoms. The cystoscope showed a papillary growth the size of the end of one's thumb, posterior to the right ureteral orifice. I also examined a fifty-seven year old woman who gave a history of hematuria with a few blood clots ten days before; no previous urinary symptoms, no loss of weight, but she had had gall bladder disease with some pain in the back. Through the cystoscope a papillary tumor the size of a walnut was seen close to the left ureteral orifice.

The degree of clinical malignancy is represented by the degree of infiltration. Haines feels that the trained and experienced cystocopist is the person to determine the kindly or unkindly nature of the bladder tumor, and that on his decision rests the proper line of treatment to pursue. In doubtful cases it may be remembered that benign and malignant tumors, both peduncular and sessile, frequently respond to the same treatment; therefore, fine distinctions are not needed for a choice of therapy. He gives a practical grouping of bladder tumors from cystoscopic inspection, and for the purpose of selecting treatment. He divides them first into two groups—those that project into the bladder space and those that do not. The first group contains the benign papilloma, papillary carcinoma, etc.; the second, the flat, infiltrated, squamous cell type of carcinoma, with rough, ulcerated, bleeding surface, devoid of villous projections. The latter



Figure 3. Cystogram, contracted bladder, small diverticulae, advanced cancer, chronic interstitial cystitis, colon bacillus infection and active bladder spasms.



Figure 4. Cystogram, advanced, inoperable infiltrating cancer involving the bladder neck, trigone and prostate. Note filling defect from five to nine o'clock.

group he finds unsuitable for fulguration. The fulgurability of tumors of the first group depends on the amount of infiltration. For those without infiltration of the pedicle or base, he finds fulgulation sufficient; those with infiltration are usually, in his opinion, not amenable to this method. Experience has shown that clean, vascular tumors, unassociated with cystitis and edema about the base, and previously untreated, may be regarded provisionally as noninfiltrating. For nonfulgurable tumors he prefers extraperitoneal excision to radium if the tumor is favorably situated and the patient physically fit. He gives a course of light cross-fire roentgen irradiation before all treatment.

Holthusen, in a text-book of urology brought out in Germany in 1929, says that a review of the world literature shows that radium dominates the field of bladder cancer therapy today, especially in America and France, but he is of the opinion that, in Germany at any rate, small accessible tumors will continue for the present to be excised.

In America, as well, the superior claims of radium over resection for resectable tumors are by no means undisputed. Barringer holds that radium is the method of choice for all types of cancer of the bladder. He recently reported the end results in cases of carcinoma treated by radium in various forms five years and more ago. Eleven of eighteen traced patients with papillary carcinoma and twelve of fifty traced patients with infiltrating carcinoma were cancer-free five years or longer. All of these patients were treated before he began to use gold seeds. Gold seeds have, he believes, decidedly increased the effectiveness of radium in controlling bladder tumors, and future results ought to be better. In cases in which there is any doubt as to success, he advises the suprapubic method as preferable to the cystoscopic method of implantation.

In Keyes' experience, thorough fulguration is sufficient for small papillary carcinomas without infiltration of the base, but if there is any doubt as to the malignant involvement of the base, a few radon seeds should be buried there. For large, multiple or infiltrating tumors, he advises radium implantation through a suprapubic incision. Keyes is confident that suprapubic radium implantation is the simplest and safest operation for large or infiltrating tumors, but he has found that primarily infiltrating tumors are almost all fatal, however treated. Within three years, he has treated eleven cases of infiltrating carcinoma with implantation of radium, and feels that one case is controlled; six patients had died, five were still under treatment.

Young advises surface application of radium plus fulguration for papillary carcinoma. In some cases he has seen good results from repeated applications of radium followed by roentgen therapy. If these methods fail, resection or, if this is impossible, superficial cauterization and radium implantation should be done.

The method selected for treating tumors of low malignancy is not, in Bumpus' opinion, of great importance. Even in extensive growths of low malignancy, the final results are excellent. If the lesion is comparatively small, he favors cystoscopic fulguration. One of the marked advantages of diathermy over resection, he points out, is the small amount of bladder contour deformity that results. In cases of greater gravity, he thinks that the main value of diathermy is in bringing within the scope of successful treatment cases formerly thought hopeless, rather than in replacing strictly surgical methods.

Eisendrath and Rolnick, in their recently published text-book, express the view that resection can only be considered for carcinoma involving very accessible areas, such as the dome and perhaps the posterior wall, and that for all other carcinomas, surgical diathermy applied through a suprapubic incision offers better prospects of cure. By this method, which is an amplification

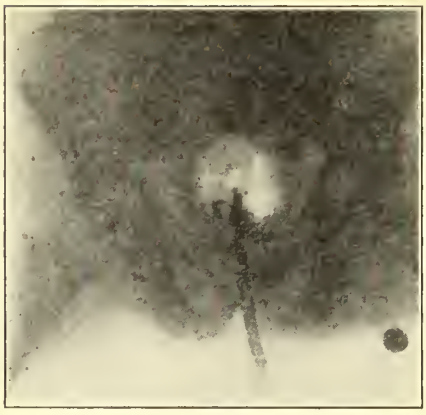


Figure 5. Airgram of Plate No. 4. Sodium iodide drained out, bladder filled with air. Tumor area distinctly seen near tip of catheter.

of the principle of fulguration, the tumor is destroyed by heat generated within itself.

Hunt holds that an operable malignant tumor of the bladder is most successfully dealt with surgically, and adds that most tumors of the dome or lateral or posterior walls are operable. Lowsley, Harrison and Judd each regrets that radical surgery has been relegated to the background.

In England surgical methods seem to be holding their own. Sir John Thomson-Walker reports that in his experience the results of partial cystectomy have been extremely good; no recurrence for three years or more in 34.5 per cent of 128 resections for malignant growths.

Morson found radium "strangely disappointing" in 1927; two years later he expresses satisfaction at temporary amelioration, up to three years, obtained by buried radium needles in thirteen of twenty-three patients with operable carcinoma and profoundly ill from hemorrhage or sepsis.

Most reports on the use of the *X*-ray curatively are unfavorable, but it has given good results in relief of nerve pain.

In desperate cases and when a malignant tumor cannot be removed without sacrificing both ureters, the question of total cytsectomy comes up. This is a terribly mutilating operation with an extremely high mortality. It is advocated by Wade and by Swift Joly in England, and by a number of men in this country. Beer did the operation seven times with transplantation of the ureters into the skin without a fatality, and saw one patient live five years and another four years. Swift Joly and Eisendrath have been pleased with the results of ureterostomy as a palliative measure, and the French urologists Legueu and Papin advocate ureterostomy or nephrostomy when the ureters are compressed by an inoperable growth, to obviate uremia and pyelonephritis.

From my own surgical experience I have gained the impression that almost all bladder tumors, whether benign or malignant, should be treated by means of the high frequency current, and that malignant tumors should be further treated by gold radon implants. Some growths in the fundic or lateral region of the bladder could, of course, be successfully treated by resection, if done early, but in growths in the deeper portions of the bladder involving the trigone and floor of the bladder neck, and where transplantation of the ureters might be necessary, I feel that as much good can be done by fulguration and implanted radium emanation as by resection. In resection of a malignant bladder tumor there is a definite risk of implanting fresh tumors, a malignant tumor being comparable to a burst seed-pod of a flower, ready to scatter its seeds at the slightest touch. Every case must be considered on its own merits, but as a usual thing we are dealing with a depleted organism, in poor condition to stand extensive operation.

My own malignant bladder tumor material of the last three years and seven months consists of twenty-six cases; in six, operation was refused. There were treated thirteen papillary carcinomas, four infiltrating carcinomas, two adenocarcinomas and one epidermoid carcinoma. The ages of the twenty treated patients ranged from forty to eighty years and the symptoms dated from ten days to ten years back. In these twenty cases there were five deaths. This number included two advanced cases of the typical infiltrating type, in which suprapubic cystotomy, to divert the urine, was the only procedure attempted. In the three other cases with fatal ending, the treatment was suprapubic fulguration and implantation of radium emanation in gold seeds. One death occurred five days after operation, probably from pulmonary embolism; another, from a rapid pneumonia, three weeks after leaving the hospital and six weeks after operation. In one case—an edipermoid carcinoma which had given symptoms for ten years—the patient appeared to be doing well for some weeks after discharge, then failed and died seven months after the operation. One patient, who had suprapubic cystotomy for drainage only, was lost sight of after one month. Two patients were observed three months or less. Of the remaining eight patients, two appear cured at the end of three and a half years. One of these patients, a woman, aged fifty-seven, had papillary carcinoma with symptoms of ten days' duration when I saw her. She was treated with cystoscopic fulguration and radon implantations. The other was a man, aged sixty-eight, with an adenocarcinoma which had given symptoms for four years. He was treated with suprapubic fulguration and radon implants. Another patient with adenocancinoma is well after twenty months. The growth which seems to be controlled at least, was treated by resection and radon implants. A man, aged seventy, is alive and well twenty-six months

after cystoscopic fulguration and implantation of radium seeds for papillary carcinoma. He had no cystitis, urine clear, and cystoscopic study negative. The other four have survived from fifteen to eighteen and a half months. One, treated by suprapubic resection for advanced papillary carcinoma, is in fair condition; the others are in good condition. One of the latter is a man of eighty, who had an infiltrating carcinoma that had given symptoms for five years. He was treated by suprapubic fulguration and radon implants, and is in good condition after eight months.

In six of my most recent cases, one refused operation, one died four months after leaving the hospital, and four are alive and well and seem to be in excellent condition.

In conclusion, I would urge that it is our duty as members of the medical profession, whether general or special, to regard seriously symptoms referable to the bladder, in the form of blood in the urine, sometimes associated with frequency and urgency of urination. These cases should be seen and investigated early with the cystoscope, and an accurate diagnosis established, inasmuch as the one outstanding symptom usually present in bladder tumors is hematuria, either with or without pain.

Once we have established our diagnosis, and have carefully visualized the location and extent of the growth through the cystoscope, then we are able to determine our method of attack, since each case is an individual problem relative to its management. For readily accessible growths, not too large in size, I, for the moment, personally favor the operating cystoscope and high frequency current and immediate implantation of gold radon emanation seeds. For larger growths, and those not easily treated endovesically, I, for the moment, prefer suprapubic cystotomy, frequently under spinal anesthesia, if conditions permit, thorough electro-coagulation and radium properly placed, emphasizing the periphery and deeper areas of the base, rather than routine resection of the growth.

We must all remember in handling these cases that we are dealing with a depleted organism, whose resistance is low, and in whom radical and extensive surgery should be considered only in the selected cases, rather than as routine procedure.

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Ocular Disorders Associated With Endocrines

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I HAVE chosen for my theme a topic of which we know little. For this very reason I feel that it deserves careful study on account of the future which it promises. The surface has just been scratched, and yet, quite a few things have been unearthed which excite a hope for still greater accomplishment. There are several ways by which this subject may be approached. Either each ductless gland may be taken in turn, and its influence, if any, on the various tissues of the eye, studied, or each separate structure of the eye can be considered as to what effect upon it, abnormality of any one or more of the glands may have. I believe the former to be the most feasible even though it may at times invite controversy. Unfortunately, in the majority of cases of eye disease considered as due to improper functioning of the endocrines, only clinical surmises have been utilized instead of careful and thorough scientific investigations for further confirmation. These clinical presumptions may be the very things which are apt to point the way to possible scientific truths or fallacies which can be corroborated or refuted by searching inquiry and study.

Rowe[1] states that: "In considering endocrine origin, one must not ignore the fact that a given symptom or condition may be the result of any number of wholly dissociated causes, and this fact must be borne in mind in establishing relationship between cause and effect. The endocrine glands are among the most important regulators of general body metabolism. The extremely complicated interwoven directorate of this mechanism must have a number of well balanced and finely adjusted governors. When a mild disorder springs up, it may be possible to fully compensate, but with serious disturbance, compensations are only partially effective, if at all. Disturbed function of one organ obviously results in change in other members of the group. Primary involvement of more than one organ may undoubtedly exist, although perhaps infrequently."

Without question, eye affections resulting from disease of the thyroid, especially exophthalmic goiter, are best known and have been most thoroughly studied. Although examination of the orbital contents have been made during life as well as at autopsy, a satisfactory explanation of the cause of the protrusion of the eyes has never been offered. Most authors believe it is due to increase of fat in the orbit. This seems strange in view of the fact that the patient may be quite emaciated otherwise. The exophthalmos may be unilateral or involve both eyes, may appear early or late in the disease, and can occur either before or after operation on the thyroid. Inability of the lid to follow the movement of the globe on looking down, or von Graefe's sign, is practically always present, as well as Stellwag's sign, the lack of blinking.

Insufficiency of convergence was described by Möbius[2] as a frequent sign, in 1883, but Trousseau[3] had observed this phenomenon in 1862. However, Foster Moore does not think that this is of much importance, because proptosis from any cause will produce difficulty in convergence. Not all authorities agree that convergence insufficiency is a common sign. Strumpell[5] thinks it is a rare occurrence. Personally, I think it is one of the most important early signs of hyperactive thyroid and that it happens long before any exophthalmos can be noted. Whenever I come across a case of convergence insufficiency in my practice, I always look for moist palms, tremor, rapid pulse and other signs of goiter. Of the unusual ocular complications of goiter, ophthalmoplegia externa, paralysis of the sixth nerve, dryness of the cornea in the late stages, corneal ulcer, optic nerve atrophy and neuroretinitis have been reported. Anisocoria has been frequently observed. Wilbrand[10] has seen contraction of the fields without fundus changes. The Cretin is the prototype of congenital thyroid failure. It is interesting to note that Radcliffe[6] reported two cases of interstitial keratitis where the usual method of treatment resulted in no improvement after several months trial. Placed on thyroid extract internally and a 3 per cent solution instilled in the eyes three times a day resulted in prompt and very striking complete clearing of the cornea taking place. Five grain doses three times daily were given, but he believed that smaller doses would suffice. Myxedema with keratitis following extirpation of the thyroid was reported by Grandclemont[7] in 1899. Panas[8] saw myopia develop during Graves' disease as have Dianoux and Pedrano,[9] Beard, and others. Gowers says it occurs rarely. This is not in keeping with our present day theories of progressive myopia.

Bothman[10] has given the results of the relation of the basal metabolic rate to progressive axial myopia. A series of ten cases was studied. They had basal rates from 0 to -32 per cent. Fifteen hyperopes were studied for comparison, where basal rates varied from -4 (one case) to +8.5 per cent, while in a series of cases of hyperthyroid, only 5 per cent were found to be myopic, and none of these had progressive myopia. We are trying to confirm Bothman's findings, and are having basal as well as sugar tolerance made in our progressive myopes. Thus far the majority of cases

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show a lowered basal rate. Marine[11] has called attention to the fact that, while the belief that exophthalmic goiter is essentially a thyroid disease still prevails, he is convinced that a much more fundamental disturbance lies in a deficiency of some function of the suprarenal cortex and sex glands, which either provides other means of promoting tissue oxidation, or had to do with the regulatory control of these oxidations. Bothman assumes that a low basal rate indicates hypofunction of the thyroid. This is unquestionably true in some cases. We know that it also occurs in hypoadrenalism and that excess of thyroid hormone stimulates the adrenal function, but the immediate effect of thyroxin is to diminish sugar tolerance. Lawrence and Rowe[1] found in their series that the values ranged from -5 per cent to -3 per cent, the net average being -17 per cent. These authors have noticed either a normal, or depressed, galactose tolerance. When extraneous effects influencing tolerance can be excluded, the dose producing melituria, if altered, moves in the opposite direction to the basal rate change and is always of moderate amount. Hemorrhages in the vitreous have been reported by Bretagne and Richard[9] and others, due to thyroid disturbance. Bartels[12] found that injection of a preparation containing a solution of pituitary proved beneficial in a case of exophthalmos following removal of the thyroid gland.

Much has been written on the relation of the parathyroids and cataract. Animal experimentation on removal of parathyroids in rats produces cataract and tetany. Peters[13] thinks that heredity and dyscrinisms are both factors in senile cataract. The endocrine deficiency may be inherited and so predetermine changes in the lens. Tetany causing cataract can be influenced, and it is worth noting previous history of cramps in the fingers or toes in many cases of cataract, and with development of lens opacities after removal of the parathyroids. Parathyroid extract and calcium are indicated. I have a case under observation now of a young girl, 22 years old, who developed cataract in the right eye about three years ago. It matured rapidly, and then was noticed in the left. Her father had been operated upon by me for cataract on both eyes while in the thirties. The right eye was operated upon, and on account of a much lowered basal rate, -24, she was given thyroid extract. There has been no advance in the opacities in the left eye since, in a period of over a year. Fisher and Trubenstein[14] found a disposition to tetany in about 88 per cent of cataract cases. Kerr and Hasford[15] report the results of the treatment of senile cataract with thyroid extract. Leonard[16] had noted disorders or absence of the thyroid or parathyroid glands in frequent association with cataract. Hildersheimer[13] gives calcium iodide internally with 2 per cent or 3 per cent solution of calcium chloride and sodium iodide, equal parts, two times a day or more. Before giving iodine internally, thyro-toxicosis must be excluded. A decided diminution of lenticular myopia was noted, indicating that the giving up of fluid altered the shape of the lens. On the other hand Lohlein showed that Roemer's series of cases carefully studied and recorded, showed that the half of these treated acted exactly like those who were not. Eiseman and Luckhardt,[17] in studies of the mechanism of cataract formation in thyro-parathyroidectomized dogs, report that cataract did not develop in the dogs in which tetany was produced by calcium deprivation and other means. Weill and Nordman,[18] and others, have attempted to distinguish the separate endocrine cataracts by the appearance under the slit lamp. Salvati[19] can see no relation between endocrine insufficiency and cataract; he considers hormone therapy worthless. Many authorities have thought there was some association between keratoconus and thyroid or parathyroid function. Torok and Ridway[20] have reported thirteen cases of conical cornea in which an exhaustive study was made of calcium metabolism. The group as a whole showed no variation from the normal fluctuation. Whereas there was improvement in vision while the thyroid was being administered, there was no change in the cone. Cammidge[21] has observed low calcium content of the blood result in retinal hemorrhages. Young[22] reported three cases of recurrent hemorrhages into the retina, and vitreous with calcium deficiency as a possible cause. In one case, calcium therapy improved the general health as well as checked the hemorrhages. We had a patient who consulted us on account of recurrent hemorrhages in the anterior chamber, following an otherwise successful cataract operation. Neither injections of serum nor giving of calcium had any effect in checking recurrences. The hemorrhages stopped immediately following a series of injections with parathyroid extract.

Most all complications of pituitary disease are dependent on direct pressure of the enlarged gland. Cushing and Walker[23] give three separate factors in pituitary disorders.

1. Neighborhood signs and symptoms shown by evidence of pressure on adjoining structures; chiasm, cranial nerves, uncinate gyra, crura cerebi and cella turcica.

2. General pressure symptoms, in case the growth becomes large enough to cause considerable cerebral deformation or to obstruct the cerebro-spinal fluid circulation by blocking the foramen of Munro.

3. Constitutional or glandular symptoms, either in the role of over or under-hypophyseal activity. Defects in the field may be:

1. Bitemporal hemianopia.
2. Homonymous hemianopia.
3. Blindness in one or both eyes.
4. Irregular defects.

Rowe[1] states that yellowish to yellow discs are

found in one-half of the pituitary cases studied by him. He has also noted enlargement of the blind spots. Exophthalmos is not infrequent. Among 91 cases Strzemski[24] found it in 17. Cushing[25] states that some degree of exophthalmos is found in all. He thinks it is due to obstruction of flow in the cavernous sinus. Uthoff[26] has observed nystagmus in 4 per cent of the cases. He has seen the third nerve involved occasionally and the sixth rarely. Igersheimer[27] declares there are cases of uveitis with hypophyseal disease as well as chronic arthritis in elderly subjects with similar choroiditis and retinal vascular disease, which, as Lichtwitz has shown, have a decided relationship to hypophyseal disease. Blue sclerotics have been attributed to the hypophysis by Gutzirt[28]. Rowland[1] states that yellow color of the discs, enlarged blind spots and contraction of the forma and color fields, are frequently observed in pituitary disease in the absence of demonstrable tumor growth. The pituitary exerts its influence through two channels, the anterior and posterior lobes. Ocular disturbance through temporary enlargement, as in pregnancy, has been observed by many. Oppenheimer[29] has suggested a circulative toxic substance derived from the gland and producing optic nerve degeneration. Sedillot[30] has offered anatomical and clinical proofs of pituitary mechanism in ophthalmic and ophthalmoplegic migraine. Gilbert[31] believes that vitiligo is due to dysfunction of the thyroid and hypophysis. Fisher[32] says that there are cases of pigmentary degeneration of the retina, associated with polydactylism which have been associated with hypopituitarism. Igersheimer[27] has seen cases of uveitis choroiditis and retino vascular disease with hypophyseal disease.

It is most difficult to prove connection of certain eye disorders as the result of gonad dysfunction, and it is quite possible that many of the conditions reported in the literature are merely coincidental. The field changes in pregnancy are undoubtedly secondary, due to the pituitary involvement. Gilbert[31] believes that there is a connection between disturbance of the female organs and iritis. He also thinks that senile degeneration of the gonads may explain fluid vitreous in old persons. He also states that loss of pigment has been noted in early made castrates. Johns[33] made an investigation on 29 cases of normal pregnancy. There was definite contraction of the form and color fields in the majority of cases. Also the blind spot was nearly always enlarged. She does not believe the changes to be characteristic of pituitary, but due to reduction of retinal vitality, and attributes the changes to be functional rather than enlargement of the pituitary as had been thought by so many. As early as 1898, Compte[34] reported hypertrophy of the pituitary during pregnancy, and has been followed by many others. Rowe and Lawrence state that pain, blurring of vision, spots before the eyes, are frequently reported in ovarian disease. Thies[35] has reported iritis observed with menstrual anomalies, relapsing phlyctenules and marginal infiltrates, severe iritis and sequelae, disseminate choroiditis, neuroretinitis and papillites, all among females, who are ten times more susceptible to endocrine disturbance than males. The dyscrinisms were expressed as hypogenitalism, obesity and myxedema. The therapeutic effect of a proprietary female sex hormone preparation, and of a preparation containing a solution of pituitary was noted as favorable. Meesman[35] questions Thies' results, even when there was apparent benefit from the hormones, although Igersheimer[35] agrees that endocrine seems to be the advisable treatment when in doubt. Chemosis of the conjunctiva during the menstrual period has been recorded by Seeligsohn[36] and hyperaemia and styes by Friedenwald.[37] Menstrual episcleritis was reported by Villard[38] in a woman of forty-two with chronic metritis. She had had attacks of moderate severity in the left eye with each period for five years. Scleral inflammation appeared eight days before menstruation, reaching its maximum with the flow and disappeared with cessation. The attack was regularly checked by removal of a small amount of blood eight days before menstruation. He explains that this phenomenon was discovered by chance in taking blood for a Wassermann. It had been striking and invariable for two years. I have seen a case of sub-conjunctival hemorrhage in a young negress recur at frequent intervals with the onset of the menstrual period. I have also seen a young girl, fifteen years of age, who gradually developed grey lashes and eyebrows on the left side, eventually resulting in almost total loss of the lashes. None of the usual methods of treatment availed. A general physical examination, including Wassermann, was negative. She was placed on ovarian extract by her physician. The lashes and brow were promptly restored with their natural color. Numerous authorities report unfavorable influence of menstruation on existing eye condition. Hasner[39] saw a complete third nerve paralysis with each menstrual period in a girl 17 which lasted three days and disappeared. A case of choroditis was seen by Hiram Woods[40] recurring with each menses. Amblyopia following masturbation has been reported by Dien,[41] Glascott,[42] Hutchingson,[43] and Spalding,[44] but no case has been found in recent literature.

There is not much in the literature relating to eye disorders caused by disturbed adrenal function. According to Rowe,[1] enlargement of the blind spots is most frequently reported in adrenal disease. Seitz[45] and Leidenius extirpated the adrenals in white rats, both parents. In one litter seven were normal and one had a double sided anophthalmos. Another litter had one case of typical coloboma of the iris and three normal rats. The third litter brought one microphthalmos with coloboma. Number one was mated again and

brought nine healthy youngsters. Also the one with anophthalmos mated with healthy rats bore 18 healthy young. Altogether 67 offspring from the above mentioned produced only three anomalies. Ishikawa[46] has reported a case of marginal corneal ectasia which he considered the result of endocrine disturbances. He took the blood pressure, which was low, and the sugar tolerance, but offers no special proofs. Mamoli[47] has been led to believe in the primary importance of constitution as the cause of vernal catarrh. Some continuation of vagotonia, hypoadrenia, and hypogonadism, being the only constant observations. The treatment consisted in subcutaneous injections of epinephrine combined with calcium intramuscularly and epinephrine and cocaine drops. de Schweinitz's[48] test with adrenalin in paralysis of the sympathetic is well known. In my opinion progressive myopia is due, in a certain proportion of cases to hypoadrenalism. In 1927[49] I made a preliminary report on the use of epinephrine in progressive myopia, and last year made a supplementary report.[50] Incze,[51] in 1929 reported a series of 188 cases. He considers the stretching of the sclera to be due to a deficiency of epinephrine in the organism, in addition to an altered condition of the endocrine function in general. We are now endeavoring to supplement our investigations in this connection by including in our examination basal metabolism, blood pressure, sugar tolerance and other tests which might help to throw further light on the subject. In considering adrenal insufficiency, or any other involvement of the endocrines, one must not overlook focal infections as a causative factor of the endocrine disorder. Rowe and Lawrence[1] have noted focal infection, especially the tonsils, in adrenal insufficiency.

It is questionable whether the thymus plays any direct part in relation to ocular disorders. Garre[52] found persistent hyperplasia of the thymus in 95 per cent of fatal cases of exophthalmic goiter. Thymus feeding in patients with goiter has been found beneficial by von Haberer[52] and also by Halstead.[52] Nicolata[53] considered disease of the thymus to be the seat of myopia. Klar[54] reported the eye symptoms in a typical picture of myasthenia gravis with thymus tumor where there was a chronic periodic remittent, intermittent course, ptosis, paralysis of the external eye muscles, and involvement of the frontal, facial, bulbar and respiratory muscles. The thymus tumor was a lymphoepithelioma without signs of malignancy. The muscle lesions were in no way similar to the tumor.

The only connection of the eye and spleen I was able to find was a case of scrofulous iritis cured by splenotherapy, reported by Fradkine.[55] A young man with a hereditary and personal tuberculous taint had inflammatory iritis in the right eye; nodular exudative iritis appeared in the left eye several months later. Splenotherapy gave rapid and excellent results in this case of scrofulous iritis with massive fibrimous exudate and a solitary nodule without involvement of Descemet's membrane.

Pancreas dysfunction is expressed in the eye by the ocular complications of diabetes. Doubt has been expressed as to whether retinitis due to diabetes alone ever occurs. In young subjects in whom the disease manifests itself in its most malignant form, and in whom the toxic elements are most prominent, retinitis never occurs. Again, it is usual to find albumin as well as sugar in the urine of patients with diabetic retinitis, and these patients almost always have an increased systolic pressure. Burch[56] states that changes in refraction are common and occur in 14.6 per cent of diabetics. There is a tendency toward myopia with sudden increase in blood sugar; toward hyperopia with a sudden decrease. This is explained by Duke-Elder[57] by osmotic physical laws. When the sugar content in which the lens is washed reaches a high point, an actual increase in the lens volume occurs, thus producing myopia. When sugar excretion is at a maximum the osmotic flow is from the lens to the intra-ocular fluids, resulting in a marked hyperopia. As sugar metabolism stabilizes, the lens volume becomes normal and its refraction reverts to its original normal. Retrobulbar neuritis is rare. There seems to be little doubt that iritis may be definitely caused by diabetes. Ocular palsies are fairly common and may occur as peripheral neuritis, but probably due at times to small hemorrhages, central or peripheral. Diplopia is most frequent to involve the sixth nerve. Lipaemia retinalis is a rare condition. The cause of diabetic cataract is not known. It is probably due to dehydration. Benedict has advised withholding insulin after operation in diabetic cataract. Insulin according to Hajos,[58] increases sensitiveness in experimental anaphylaxis. Collevati reported changes in the ciliary body and lens in experimental hyperglycemia.

Dinger[59] has reported the case of a girl of 15 with bilateral displacement of the lens and pupil as coefficient of constitutional anomaly, which he associated with endocrine disturbance. Glaucoma has been considered by some to be due to ductless gland disease, the adrenals, among others having been blamed. Rowe[60] made a study of 27 cases in which there was endocrine established in one, doubtful in two, not established in twenty-four, and incomplete in four others not included. He concludes that there is no real evidence to support the contention that there is a significant endocrine factor in the etiology of glaucoma.

In conclusion, may I recall Fuch's admonition that because an inflammation or disease of the eye is found to be associated with a disturbance of one of the ductless glands, is no reason to assume that it is due to the endocrine disease. The same thing which caused the pathological con-

dition of the ductless gland may also have produced the eye disease. I suggest that in all cases where there is suspicion that one or more of the ductless glands may be a factor in the cause of a certain disease or condition, that all of the usual careful tests be made so as to establish or refute, as nearly as possible, the truth of the assumption.

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The Results of Glucose Tolerance Tests In Pregnant Women

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THE frequently observed presence of glycosuria in pregnancy was thought to be of enough interest to warrant the study of a group of such cases by means of the glucose tolerance test in order to determine the presence or absence of diminished tolerance. Crook[1] found 166 out of 548 patients who at one time or another had glycosuria.

Forty-nine consecutive pregnant women from the out-patient department of Mt. Sinai Hospital were taken. A glucose tolerance test was done on each patient. This consisted of examining blood and urine specimens simultaneously at periods to be discussed later. No attempt was made to determine the character of the reducing substance since blood sugar and urine determinations were done simultaneously and since the reliability of blood sugar readings as opposed to interpretations of reducing substances in the urine is well known. In addition to this, it was felt entirely justifiable to believe that any reducing substance found was glucose and not lactose because of the fact that in none of the cases was there a reducing substance found before glucose was given preparatory to the tolerance test.

The method used was as follows: each patient was told to come to the out-patient department without breakfast. Samples of blood and urine were taken for examination. The patient was then given 100 grams of glucose dissolved in 200 cubic centimeters of warm water. This solution was chilled in order to eliminate nausea and vomiting as much as possible. If vomiting occurred the test was not done. Then blood and urine specimens were taken one-half hour, one hour, two hours and three hours after the glucose was given. At the same periods that specimens were taken the patient was given 200 cubic centimeters of water so that succeeding urine specimens would be obtained. The urine was examined with Benedict's solution. The blood was examined by the Folin-Wu[2] method.

The results tabulated and the standards adopted were those recommended by Mosenthal[3] as shown by Chart 1. They have been placed in the following groups: (1) Normal, (2) high, (3) prolonged, (4) high and prolonged, (5) low. The criteria used to place the cases in each class were as follows: (1) A normal fasting blood sugar was one below 120 mg. per 100 cubic centimeters of blood, (2) a high blood sugar was one over 160 mg. per 100 cubic centimeters of blood, (3) a prolonged curve was one in which the blood sugar did not return to normal level of below 120 mg. per 100 cubic centimeters of blood in three hours instead of two hours as Mosenthal has suggested. The occurrence of the second, third or

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From the Diabetic and Pre-natal Clinics of Mount Sinai Hospital.

CHART ONE

STANDARD FOR BLOOD SUGAR CURVES

TYPE OF CURVE	BLOOD SUGAR mgms. per 100 c.c.		DURATION OF CURVE (minutes)	SIGNIFICANCE
	Fasting	Highest		
NORMAL	120 —	120 + 160 —	180 —	Normal sugar tolerance.
HIGH	120 ±	161 +	180 —	Diminished sugar tolerance.
PROLONGED	120 —	160 —	181 +	Diminished sugar tolerance.
HIGH PROLONGED	120 ±	161 +	181 +	Diminished sugar tolerance.
LOW	120 —	120 —	0	Increased sugar tolerance.

1. The curve is considered to terminate when the blood sugar returns to a level of 120 mgms.

combination of second and third was interpreted to mean a diminution in tolerance. Increased tolerance was indicated when none of the blood sugars rose above 120 mg. per 100 cubic centimeters of blood.

In addition to this, an attempt was made to discover whether the weight of the patient, the month of pregnancy, or the number of preceding pregnancies played a role in altering the tolerance for glucose.

The weight of the patient was observed because Joslin and others have emphasized the role that obesity plays as a predisposing etiological factor in diabetes. That obesity does play a role can be verified by anyone who sees a great number of diabetic patients since about 85 to 90 per cent of these patients give a history of precedent obesity. The table of normal weights used was the one suggested by Joslin.[4]

The month of pregnancy was noted since Frank and Nothman,[5] Wetz and Van Netz,[6] and Bauer[7] have stated that glycosuria following an excess of carbohydrate can be constantly produced in the first three months of pregnancy and, therefore, recommend the glucose tolerance test as a certain diagnostic sign of pregnancy. However, Seitz and Jess[8] detected glycosuria in only half of the cases examined and denied the value of the test from a diagnostic point of view. Scheffey[9] concludes that "the sugar test is not reliable as an accurate diagnostic aid in pregnancy."

The number of preceding pregnancies was noted since the suggestion has been made that pregnancy, especially repeated pregnancies can lead to diabetes mellitus.[10]

Of the 49 cases examined, only 21 cases showed perfectly normal responses as measured by their blood sugar level. Of these 21 cases, seven cases had normal blood sugar readings but were abnormal in that sugar was excreted in the urine below the threshold of excretion of sugar, which has been placed at 170 to 180 mg. per 100 cubic centimeters. These have been classified as renal glycosuria. They will be discussed later. With the exception of four cases which showed increased tolerance, the others, or 23 cases, showed definite diminution in tolerance for carbohydrate.

The seat of this disturbance is still a much debated question.[10] "Van Jaksch, Bauer and Payer pointed out that the difficulty was due to a functional disturbance of the liver. Walthard did not find any great difference in response to glucose during pregnancy. He found that injection of adrenalin had no effect on blood sugar. He also found urobilinuria in 80 per cent of his cases: the amount became higher in the last three months. Schickele, Magnus Levy and Ehrenfest did not believe there was any liver disturbance in pregnancy. Lepine felt that the disturbance was due to a glycolytic insufficiency of the tissues as the result of disease of the pancreas. Siortori and Falco contended that the islands of Langerhans show histological evidence of diminished activity. This has been disputed by Pepere and Cuilla. Carlson and Ginsberg claimed that their experiments showed that during pregnancy the pancreatic insufficiency produced by total pancreatectomy was compensated for by a hyperactivity of the islands of Langerhans in the foetus. Labbe and Chevki did not believe the above occurred. At some time or another all the other endocrine glands have been incriminated. Hyperactivity of the thyroid, surprarenal, hypophysis, in the course of gestation have been used to explain glycosuria in pregnancy. Schaeffer considers pregnancy glycosuria as the result of hypersecretion of the hypophysis or suprarenal and as a consequence a hypertonia of the sympathetic system. The hypophyseal theory of the causation of glycosuria is sponsored by Ehrenfest. Some authors attribute to the ovary an importance in the metabolism of carbohydrate. Fellner, Wurslet and Justner emphasize the part

CHART TWO

RESULTS OF CASES STUDIED

Case Number	Before Glucose	½ Hour After Glucose	1 Hour After Glusose	2 Hours After Glusose	3 Hours After Glusose	Weight	Normal Weight	Month of Pregnancy	No. of Preceeding Pregnancies	Type of Curve
1.	100 neg	139 neg	122 neg	107 neg	105 neg	105	120	2	Primip	N
2.	111 neg	125 neg	91 neg	80 neg	100 neg	109	121	2	2	N
3.	77 neg	131 neg	137 neg	91 neg	95 neg	121	120	3	Primip	N
4.	105 neg	137 neg	153 neg	121 neg	133 neg	137	126	7	2	P
5.	83 neg	153	160 neg	142 neg	89 neg	134	119	3	Primip	N
6.	106 neg	159	142 neg	128 neg	120 neg	114	115	7	2	N
7.	90 neg	133 neg	160 neg	143 neg	116 neg	127	120	7	1	N
8.	93 neg	115	113 neg	100 neg	120 neg	136	123	6	1	L
9.	104 neg	117 neg	153 neg	120 neg	114 neg	166	133	7	3	N
10.	80 neg	134 neg	118 neg	105 neg	120 neg	135	112	6	Primip	N
11.	96 neg	157 neg	95 neg	94 neg	84 neg	129	120	8	1	N
12.	105 neg	119 neg	117 neg	117 neg	117 neg	147	122	4	Primip	L
13.	81 neg	100	88 neg	97 neg	78 neg	130	120	6	2	L
14.	86 neg	152	144 neg	126 neg	121 neg	126	126	7	Primip	N
15.	91 neg	161	161 neg	149 neg	118 neg	156	125	5	4	N
16.	98 neg	125	129 neg	123 neg	113 neg	154	135	7	1	N
17.	89 neg	139 neg	144 neg	113 neg	107 neg	144	126	5	1	N
18.	86 neg	132	111 neg	165 neg	141 neg	148	123	7	Primip	P
19.	91 neg	139	101 neg	108 neg	132 neg	132	119	5	Primip	P
20.	123 neg	190	214	168	101	142	126	6	3	H
21.	81 neg	192 tr.	161 tr.	113	93 neg	180	142	7	2	H
22.	105 neg	162	222 neg	168 neg	150 neg	144	117	6	2	HP
23.	105 neg	222	210	142	132	120	117	5	Primip	HP
25.	82 neg	210	164 neg	153 neg	83 neg	101	117	4	Primip	P
26.	91 neg	216	259	122	81	191	123	9	2	H
27.	86 neg	156	239	153	105 neg	175	136	6	1	H
28.	116 neg	192	160	138	121 neg	225	138	4	3	HP
29.	105 neg	158	222	181	122	191	122	5	Primip	HP
30.	80 neg	185	243	200	133	162	119	6	6	HP
31.	130 neg	153 neg	161 neg	166 neg	181 neg	181	127	6	5	HP
32.	85 neg	156	169	198	165	118	118	5	1	HP
33.	91 neg	138 neg	168 neg	146 neg	133 neg	203	126	7	1	HP
34.	112 neg	190	208	133	109	146	133	3	2	H#
35.	91 neg	173	196 tr.	141	162 tr.	130	115	8	Primip	HP#
36.	80 neg	115	105	96	86 neg	124	122	5	2	L#
37.	87 neg	166	90	87	77 neg	159	124	6	Primip	H#
38.	109 neg	160	143	123	99	150	127	6	Primip	N#
39.	102 neg	153	122	117	109	137	118	7	3	N#
40.	85 neg	130	133	137	129	150	127	4	Primip	P#
41.	93 neg	166	151	129 neg	125	158	116	5	2	HP#
43.	103 neg	129	105	125	120	125	127	7	2	N#
44.	85 neg	154	175	158	108	143	122	6	1	H#
45.	79 neg	137	119	95 tr.	91 neg	185	120	6	1	N#
46.	89 neg	143 neg	117 neg	100 neg	86 neg	98	125	7	Primip	N
47.	77 neg	142	127	111	105	115	116	7	Primip	N#
48.	98 neg	156	133	105	98	129	124	6	Primip	N#
49.	88 neg	160	139 neg	142	120	152	122	6	Primip	N#

N.—Normal, H—High, P—Prolonged, HP—High Prolonged, L—Low, #—Presence of Renal Glycosuria.

that the ovaries play but differ in the conception of the mechanism at work.

Hirschfeld believed that nervous women were more prone to pregnancy glycosuria. Von Noorden invoked the idea that it was due to a hyperexcitability of the chromaffin system and in addition a hyperexcitability and thyro-toxic insufficiency of the pancreas.

Kleesattel believes that the sugar in the urine of pregnant women is correlated with low alkali reserve.

Frank and Nothman have believed that the glycosuria was due to a renal glycosuria. This renal glycosuria has been explained on a change either in the reaction or chemical constituents of the blood. Allen and Wishart[11] in summarizing the principal facts bearing on the question of renal threshold have said in part that "a brief glycosuria is attended by a lowering of the sugar threshold of the normal kidney, so that as the hyperglycemia is subsiding sugar continues to pass into the urine with a lower level of blood sugar than that which is necessary to cause glycosuria at the outset." In the series here reported in addition to the seven cases mentioned above, 16 additional cases of renal glycosuria were found in the group showing diminished tolerance, i.e., 23 cases out of 49 showed renal glycosuria. It is admitted that strictly speaking these cases do not satisfy the standards that have been set up for undisputable renal gygcosuria.

All the above comments would certainly appear to indicate that while it is generally agreed that there is some disturbance in carbohydrate metabolism during pregnancy, there certainly is no unanimity of opinion as to the seat of trouble. As above stated, in the series here reported, 23 out of 49 cases show a diminution in tolerance.

The question of whether there is any relationship between the weight of the patient and the result obtained in glucose tolerance tests presents some slight difficulties, since no absolutely reliable figures can be obtained as to the weight of the uterine contents during the different months of pregnancy. DeLee[12] quotes the figures given by Hecker and Gassner in regard to the weight of the patient in the later months of pregnancy. "The body weight increases in the last three months as follows: Seventh month, 2400 gm.; eighth month, 1690 gm.; ninth month, 1540 gm. The increase in weight is due to (1) the fetus and secundines; (2) increased assimilation; (3) storing up of fat and albumin; (4) accumulation of water, especially in the lower extremities; (5) increase of the amount of blood. A gravida gains one-thirteenth of her body weight during pregnancy." Fifteen pounds has been taken to represent rather conservatively the weight of the pregnant uterine contents during the last four to five months of pregnancy. All cases showing only this variation between the estimated normal weight and the weight taken on the day of examination have not been considered in the results that follow. Of the 49 cases studied, 24 were found to be overweight. This varied from 15 pounds in Case 5, who was only three months pregnant, to 87 pounds. Of the 22 cases that gave normal responses to glucose, only eight cases were found to be overweight; on the other hand 15 cases out of the 23 showing diminished tolerance were overweight. In other words, while the number in each group was about the same, i.e., 22 normal tolerances and 23 diminished tolerances, obesity occurred almost twice as often in the group of diminished tolerance. From this, it appears to be fair to assume there is some relationship between the presence of obesity in pregnant women and diminished tolerance for glucose. The observation further supports the prevailing opinion expressed by many authors that all obese individuals are candidates for diabetes, but not all are elected.

In regard to the statment made that glycosuria can be constantly produced in the first three months of pregnancy following an excess of carbohydrate, it is of interest to note that of the five cases admitted to the out-patient department, four cases had perfectly normal tolerance tests. The small number of cases of early pregnancy presenting themselves can be very easily explained when one considers that dispensary patients do not come for examination until they are very much further advanced in their pregnancy. It is of interest to note that in the later months of pregnancy, when more patients were admitted, the results differed. For example, in the fifth month of pregnancy, there were six out of nine

CHART THREE

RELATIONSHIP BETWEEN NUMBER OF PRECEDING PREGNANCIES AND THE RESPONSES TO GLUCOSE

No. of Preceding Pregnancies	No. of Cases	No. of Cases Showing Normal Tolerance	No. of Cases Showing Diminished Tolerance	No. of Cases Showing Increased Tolerance	No. of Cases of Renal Glycosuria
Primip	20	10	9	1	9
1	9	4	4	1	3
2	11	3	6	2	6
3	4	2	2		3
4	1	1			
5	1		1		
6	1		1		1
7	2	2			1

cases showing diminished tolerance; in the sixth month, eight out of fifteen cases, while in the seventh month, only four out of thirteen. The results would certainly tend to support the work of Allen.[13] He concluded from his experimental work on dogs that there was a distinct lowering of carbohydrate assimilation in the later months of pregnancy. He differed with Carlson and collaborators[14] who felt "that diabetes in the latter part of pregnancy may be prevented by the internal secretory activity of the pancrease."

As to repeated pregnancies being responsible for the occurrence of diabetes, I have no figures, but if we grant that diminished tolerance as shown after the ingestion of an excessive amount of glucose may be one piece of evidence pointing toward potential diabetes, then Chart 3 may give some interesting data. This chart has been made with the idea of learning the relationship between the number of preceding pregnancies and a diminution in tolerance for glucose. The cases were grouped according to the number of preceding pregnancies and the results noted. In looking over the chart, one finds that the percentage of cases showing abnormal responses is around 50 per cent in those groups where there is more than one case. In fact, in the two cases where there had been seven preceding pregnancies, the response was normal in both cases. Obviously, these 49 cases are too small a series from which to draw any conclusions. However, since the percentage of occurrence is about the same, one might be justified in venturing an opinion that repetition of pregnancy plays no part in the production of diabetes.

CONCLUSIONS

(1) The positive findings in 23 of the 49 cases examined harmonizes with the view that there is some disturbance in glucose metabolism in pregnancy, the cause of which is still undetermined.

(2) Obesity itself may produce a lowering in tolerance and since fifteen of the 23 cases with diminished tolerance were obese, a question is suggested as to whether obesity and not pregnancy is the determining factor.

(3) The glucose tolerance test cannot be used as a method of diagnosis of early pregnancy.

(4) Repetition of pregnancy does not appear to play any part in the production of diabetes.

I am deeply indebted to the laboratory staff of Mt. Sinai Hospital for the technical help in the preparation of this paper.

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DISCUSSION

HENRY J. JOHN, M.D., Cleveland: Dr. Selman has presented interesting data, concluding that obesity plays a very important part in the etiology of diabetes. This is a fact conceded by all workers in this field. In my analysis of 3000 cases of diabetes this was present in about 80 per cent of cases. Other authors give figures as high as 90 per cent. There are really two big etiological factors in diabetes, namely, obesity and infection. If you take these two, then the remainder of factors will represent but a small percentage.

Regarding the repeated pregnancies: I have two cases on record who were normal during the early pregnancies and developed diabetes during subsequent pregnancies. I don't mean to infer that it was pregnancy per se which caused the diabetes, but merely that if a woman is well during first few pregnancies this is no safeguard that she may not develop diabetes at some later pregnancy stage. Pregnancy itself has perhaps nothing to do with it, but rather over-eating or infection.

Glycosuria during pregnancy is not an infrequent finding. I feel that when one meets with it, there is but one point of importance—is it diabetic or is it non-diabetic? One need not waste time trying to differentiate what kind of sugar it is in the urine for that point is of no practical importance either to the patient or to the doctor. The point is, is that patient diabetic? The answer to that question can be definitely settled by a glucose tolerance test which will differentiate between the two conditions. One need not, however, subject a pregnant woman to the long and strenous test, for you can get a practical answer to this question by the short-cut method, namely, have her eat a heavy carbohydrate meal and check her blood and urine exactly two and one-half hours after such a meal. If the blood sugar is normal, then you can consider diabetes as ruled out with a fair degree of safety. On the other hand, if the patient is even mildly diabetic, she will show a hyperglycemia at the two and one-half hours period. In this manner, but a single blood sugar examination will settle the problem.

Regarding the glucose tolerance tests in pregnancy, I can offer you data of 31 cases in my own series. The information from these runs parallel to that which Dr. Selman gave. I feel that we will get similar answers from any other author working in this field. Of the 31 cases of glycosuria of pregnancy which had glucose tolerance done, 50 per cent gave a diabetic curve and 50 per cent a normal one. Of those that gave a normal curve, 88 per cent showed normal weight and 12 per cent obesity. Of those showing a diabetic curve only 23 per cent showed normal weight and 77 per cent were obese. These figures I feel speak for themselves and need no comment.

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Physical Findings In Mental Disease

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IN presenting this paper, it is not our purpose to enter into any controversy over the relation of physical to mental disorders. This question has been the subject of much debate and the arguments have usually ended about as far from solution as when started. Consequently, no attempt is being made to establish any etiological connection between the two conditions. We do hope, however, to present evidence which will show that a great deal of physical pathology exists in persons suffering from morbid mental conditions.

In this connection, however, it may be mentioned that there is a considerable number of mental disorders in which the physical connection is generally recognized and some instances frankly admitted as being of specific etiological significance. For instance, in the official classification of mental diseases, as adopted by the American Psychiatric Association, we find in approximately one-half of the major types of psychoses that physical pathology is accepted as being directly and etiologically associated with the mental disorder. For example, we have the senile arteriosclerotic group, the neurosyphilitic group, the inflammatory and degenerative diseases of the Central Nervous System, such as, encephalitis, disseminated sclerosis, paralysis agitans, the choreas, brain abscess, tumors, etc. We also recognize the various metabolic diseases, the endocrine disorders, the psychoses due to drugs, alcohol, and other exogenous toxins, as instances of conditions in which there is a direct connection between the physical pathology and the mental manifestations.

In addition to these, we have, however, a large group of so-called functional mental disorders, composed largely of the schizophrenias, manic depressives, and psychoneurotics, in which physical pathology has not been established, or recognized, as being of specific significance. In these functional disorders, unresolved or inadequately resolved psychic conflict has in general been accepted as the etiological factor. However, in these psychoses we frequently find physical disorders which in some instances may exist as factors which might favor the development of a psychosis, or impede recovery.

For instance, Hoskins and Sleeper[1] in their Endocrine Studies of Dementia Praecox, have based their investigations on the primary conception that "dementia praecox is a reaction to a sense of personal failure arising primarily from a feeling of inadequacy to meet the issues of life in such a way as to secure a tolerable degree of emotional repose. They share with Janet the belief that fundamental to the disorder in each case is a lack of nervous energy leading to a feeling of inadequacy and a consequent flight from reality. From these premises, they reason that it would seem logical to assume that morbid mental states might develop in relatively strong individuals as the result of overwhelming difficulties, or in weak individuals as the result of relatively trivial difficulties."

Accepting this viewpoint, it might be argued that the individual handicapped by physical disability of any kind is less adequately equipped to meet and resolve mental conflict than the person who has no such handicap. Disregarding, however, the possibility of even this remote connection, we feel that any person suffering from mental disease should be given a thorough and complete clinical and laboratory examination, and where physical pathology exists every effort should be made to correct it. In hospitals for mental disease, this kind of service should be available. The custodial type of treatment is already a thing of the past. In this connection, we would like to quote from the Tenth Annual Presentation of Hospital Data by the Council on Medical Education and Hospitals of the American Medical Asociation.[2] This report, recently published in *The Journal, A. M. A.*, in the section on Hospitals for Nervous and Mental Patients, states that "the increasing medical interest in this group of institutions, until recently thought of as custodial only, has already resulted in changing, to a degree, their atmosphere. Clinical, laboratory, *X*-ray department, physical and occupational therapy departments, and other diagnostic and therapeutic facilities are being added. Thus making these institutions places for reconstruction, rather than for merely incarceration."

In presenting the subject of Physical Findings in Mental Disease, we realize that it is too large to attempt any detailed analysis.

Hence, we intend to confine the discussion largely to the findings obtained in special diagnostic clinics conducted at the Toledo State Hospital and reported principally by the following divisions—enterology and proctology, genito-urinary diseases, eye, ear, nose and throat, endocrinology, and to some extent, the *X*-ray and clinical laboratories. The findings in the first four of these departments have been made by visiting and consulting specialists, who are not directly concerned with the patient from the psychiatric viewpoint. Hence, their examinations and reports should be free from prejudice.

In the department of enterology and proct-

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Toledo State Hospital.

ology, a series of 299 male patients were routinely examined shortly after their admission to the hospital. In 147, or 49 per cent of these, pathology of some kind was reported. The pathological findings include hemorrhoids, fissures, strictures, fistulas, proctitis, colitis, colonic stasis, etc. Some of the actual reports are as follows:

Male. Age 44.—Complete anterior rectal fistula, with hemorrhagic proctitis.

Male. Age 40.—External and internal hemorrhoids. Inflammatory mucous colitis, with retention of fecal matter in the ampullae.

Male. Age 37.—Central hemorrhoid. Anterior rectal fissure, with atrophic proctitis and colitis.

Male. Age 40.—External and internal hemorrhoids. Two tumor masses attached to the right and left walls of the ampullae. Unable to pass sigmoidoscope by this obstruction.

Male. Age 45.—Grangrenous hemorrhoids.

Male. Age 31.—Right and left internal hemorrhoids. Post-rectal fissure. Colonic stasis, with fecal retention in the ampullae.

Male. Age 37.—Multiple fistula posteriorly. Marked stenosis of the rectum, a mass is palpable in the posterior portion.

In the genito-urinary department, 382 patients, 206 of which were male and 176 female, were examined during the past year. Practically all of these examinations were made on persons recently admitted to the hospital. In 198, or 52 per cent of these, pathology was reported. The findings include almost all of the common genito-urinary disorders and occasionally some of the less common conditions. Some of the actual reports are as follows:

Female. Age 22.—Thick purulent urethral discharge present. Bartholin's glands not palpable. Cystocele present. Perineum relaxed and shows evidence of former laceration. Cervix and uterus negative. Some tenderness in the region of the right tube and ovary. The left tube is thickened.

Female. Age 45.—Perineum relaxed and shows evidence of former laceration. Small cystocele and rectocele present. Catheterized specimen of urine is very cloudy. Bladder capacity 11 oz. Cystoscopic examination shows many large trabeculations in the fundus of the bladder, with a marked trigonitis. Right ureteral orifice is inflammed and discharging considerable pus.

Female. Age 32.—Large urethral caruncle present. Cystocele and rectocle present. Perineum shows evidence of former laceration. The cervix is eroded and mucous cervical discharge is present.

Female. Age 45.—Mucopurulent urethral discharge present. Marked cystocele and rectocele. Perineum shows evidence of laceration. Cervix is enlarged. Uterus enlarged and antiflexed. There is a large mass in the region of the left tube. Cystoscopic examination shows many large trabeculations in the fundus of the bladder, with marked trigonitis.

Female. Age 29.—Cervix lacerated and thick profuse purulent cervical discharge present. Uterus is enlarged, hard and about twice its normal size. Catheterized specimen of urine is cloudy due to pus. Cystoscopic examination negative, except for a few small papillomata on the trigone of the bladder.

Female. Age 48.—External urinary meatus is stenosed. Bartholin's glands indurated. Marked cystocele and rectocele present. Perineum relaxed. Cervix eroded and lacerated. Uterus retroverted.

In the Eye, Ear, Nose and Throat department, 328 patients were examined during the year, 176 male and 152 female. Practically all of these examinations were also made on routine admissions. The reports showed pathology in 148, or 45 per cent of these cases. In 24 per cent of the patients examined, septic and infected tonsils were found. Some of the actual reports, characteristic of the more severe type of pathology, are as follows:

Female. Age 47.—Tonsils have been removed. Polypi from ethmoiditis on the left side of the nose.

Female. Age 45.—Small tags of tonsils present. There is chronic catarrhal otitis media in both ears.

Female. Age 41.—Tonsils show two abscesses under the tissue, if the skin were broken, the pus would pour out. Slight deflection of the septum to the left. Ears negative.

Male. Age 24.—Tonsils are badly infected. There is a granular pharyngitis and marked halitosis.

Female. Age 32.—Atrophic bilateral rhinitis. The turbinates are almost entirely destroyed. There is a purulent, offensive nasal discharge.

Female. Age 25.—Tonsils are septic and should be removed. There is an impaction of the middle turbinate bone and a slight deflection of the septum to the right.

Male. Aged 27.—Tonsils are small. There is a marked deflection of the septum to the right. There is a chronic suppurating discharge from the right ear and a chronic otitis media in the left ear.

Male. Age 29.—Tonsils are septic and should be removed. There is an impacted turbinate on the right side, with a pus discharge, suggesting ethmoiditis. There is a chronic suppurating otitis media in the right ear with a perforation. The left ear drum is also perforated, but no discharge.

Male. Age 34.—Medium size submerged tonsils. Deflection of the septum to the right. Chronic otitis media in both ears, with some retraction of the drums.

Male. Age 38.—Small submerged tonsils. Halitosis. Marked deflection of the septum to the right. Acute suppurating abscess in the right ear.

In the department of endocrinology, 135 of the 1930 admissions were referred for special examination. Sixty-one of these showed evidence suggesting endocrine disorders. This figure constitutes approximately 10 per cent of the total admissions. Most of the findings were thyroid disorders. A few of the actual reports are as follows:

Female. Age 42.—Examination shows a nodular goiter, about three times the normal size. There is a fine tremor of the hands. Pulse rate moderately increased. Diagnosis—Toxic goiter.

Female. Age 47.—This patient has an enlarged thyroid, tachycardia, tremor of the hands and is suffering from hyperthyroidism.

Female. Age 20.—Examination shows a moderate enlargement of the thyroid about twice its normal size. Enlargement is smooth and sym-

metrical. There is no tremor, no tachycardia, no exophthalmos. The symptoms suggest a mild hypothyroidism.

Female. Age 23.—Examination shows an enlargement of the thyroid, twice the normal size, smooth and symmetrical. Skin is moist. Moderate tachycardia. Some evidence of nervousness. Symptoms suggest a mild thyrotoxicosis.

Female. Age 45.—There is an enlargement of the thyroid with definite thyrotoxicosis, abnormal pulsation of the carotid arteries, tachycardia, abnormal moisture of the skin, exophthalmos, marked tremor of the hands. Diagnosis—Toxic thyroid.

In addition to the findings in these special diagnostic clinics, there are the gross physical lesions, such as occur in the cardiovascular, respiratory, gastro-intestinal and central nervous systems, and the manifestations of disease elicited by clinical laboratory investigation. Evidence supporting the rather frequent occurrence of the more malignant types of physical disorders, is shown by the fact that in the seven Ohio State hospitals for the civil insane, during the year of 1930, 50 per cent of the deaths were in persons whose hospital residence had been less than one year; 36 per cent in persons whose residence had been less than three months; and 20 per cent in persons who had been hospitalized less than one month. In these seven hospitals, 58 cases of manic depressive psychoses died within one year after the date of admission, 37 died within one month after admission. A survey of 100 consecutive admissions during the year of 1930 at the Toledo State Hospital, which does not include the senile arterio-sclerotic group, showed, upon critical physical examination, evidence of pathology in 76 per cent of the cases. During the first quarter of 1931 at the Toledo State Hospital, 190 patients have been confined to bed in sick hospital wards with various types of physical disease.

In the dental department, a great deal of pathology has been found. Its importance in the hospitals for mental and nervous disease has long been recognized. The *X*-ray laboratory has been valuable in diagnosing such conditions as colonic stasis. Two years ago, a paper was read before this section on Colonic Therapy in Mental Disease. At that time, the value of the *X*-ray in diagnosing colonic stasis was definitely shown and evidence presented demonstrating that in many of the functional mental disorders, a stasis of a week's duration was relatively common and in some cases the duration of the stasis exceeded three weeks. Brief mention may here be made concerning one case, which has been of particular interest, that of a young girl in her twenties suffering from manic depressive psychosis, extremely depressed and toxic. *X*-ray examination in October, 1929, showed that the colon was almost completely filled with barium three weeks after the administration of the meal. Colonic irrigation treatments were instituted and continued up until a few months ago. At times her condition became so acute and her toxicity so pronounced that it seemed doubtful whether or not she would live. A short time ago, it was noticed that her colonic irrigations were becoming more effective. One or two irrigations accomplished more than five or six had previously done, and with the disappearance of her colonic stasis, her toxic condition cleared up. She commenced to gain in weight, rapidly made a complete recovery and has been released from the hospital. Following her recovery, an *X*-ray examination of the colon showed that practically all the barium had been eliminated in forty-eight hours.

Without attempting any analysis of the more major types of physical disorders, we feel that sufficient evidence has been presented to show that there is a great deal of physical pathology associated with mental disease. In many instances, however, the pathology may be more or less obscure and in order to demonstrate its presence more than a superficial investigation is required. For instance, a young man was recently admitted suffering from an acute psychosis. His initial general physical examination report was essentially negative, except for the statement that he had an inflammation of the tonsils. After examination in the various clinical departments, it was found that his tonsils were extremely septic, that he had two impacted third molars, a moderately enlarged thyroid, with accompanying clinical symptoms indicating a thyrotoxicosis. In addition to this, he had an intense acne involving the entire face which had caused him considerable concern and worry. Many instances parallel to this could be mentioned if time would permit.

When such conditions exist, what should be the attitude of the hospital? Can any substantial argument be established to show why these conditions should be ignored, or disregarded? As this paper was being prepared, a letter was received from the mother of the man just referred to, urging that the teeth be extracted. She quoted medical authority to the effect that in some insances insanity had been cured by such procedure.

Professor Weygandt,[3] writing on the Modern Treatment of Mental Disorders in German Hospitals, in a recent issue of the *American Journal of Psychiatry*, states that "the mental asylum must be a hospital in the full sense of the word, the institution being adapted to special requirements of psychiatry."

A. L. Bowen, Superintendent of Charities of the Department of Public Welfare in the State of Illinois, writing recently in the *Welfare Bulletin*[4] in connection with the building program of that state, says that "the next two years should witness the realization of constructive thought upon building plans that shall contribute to treatment and to the great movement to acquaint our civil population with the fact about nervous and mental disease. Along this line may be mentioned the proposed diagnostic center at each of our state

hospitals, where an examination, physical and mental, may be made that shall compare in thoroughness and completeness with that given at Mayo's or any other hospital of the same rank."

Anyone suffering from a psychosis should be considered as having a grave disability, especially if the psychosis has been severe enough to necessitate hospitalization. If those institutions which care for such cases are to be hospitals, in the full sense of the word, it is essential that physical diagnostic and therapeutic facilities, comparable to the modern general hospital, should be available.

There is a growing tendency, in mental hospitals throughout the country, to establish more adequate visiting and consulting clinics in the various fields of medicine to assist the resident staff in making possible a thorough all-round medical examination of every new patient admitted. The patient-as-a-whole is a unit and must be studied as such in making a psychiatric diagnosis. The hospital that makes the most thorough and efficient diagnostic survey in this respect will have, we believe, a larger percentage of patients classified in the psychosis with other somatic disease group, than the hospital that gives less attention to physical diseases.

DISCUSSION

JOS. FETTERMAN, M.D., Cleveland: Dr. Kaiser is to be commended highly for this excellent essay, which emphasizes the concept of the patient as a whole. This enumeration of physical defects points out the need for physical care. It leaves no doubt but that mental hospitals must furnish more than custodial care. The body also must be treated to help the mind.

This concept is the theme of many recent writers, whether their opinion about nervous diseases be structural or psychogenic. Berry, in his book, "Brain and Mind" demonstrates clearly that neurones may be influenced in their functional performance by the state of health. Block, in a paper on Epilepsy, makes the forcible suggestion, "Put the patient in the best physical condition as a preliminary for treatment". And even for purely mental ills, these words of a psychiatrist are apropos, "I give my patient food and rest, I put him in good physical shape, and then I let him resolve his own conflicts".

I should like to mention a brief case history which illustrates clearly what Dr. Kaiser's paper points out:

A youth of 20, pale, shy, shuffled into the Lakeside dispensary and was referred to the Neuropsychiatric clinic. He complained that he was worthless, that his body was decaying. He gave as his reasons for this opinion that he himself could smell the odor. Furthermore, he noticed that when people walked in the street near him, they sometimes turned backwards, or that they would cross to the opposite side. As a result, he gave up his job and withdrew from practically all activities so as not to offend anybody.

Examination revealed, in addition to a marked inferiority feeling and this delusion about decay, a peculiar nasal disturbance in the form of a catarrhal process which was probably producing a disturbed sense of smell—parosmia.

The young man was sent to the ear, nose and throat department. Here a course of active treatment cleared the nasal infection. When the peculiar odor disappeared, the delusion, based upon this symptom also vanished. This treatment, plus psychotherapy, accomplished a prompt "cure."

I should like to ask Dr. Kaiser the following questions:—

Granting the need for physical care, even operative procedures, do mental cases co-operate sufficiently?

It may be practical to enumerate a list of physical findings, yet is it not extremely difficult to evaluate them? Where cause and effect are intermingled, does it not task the wisdom of a "diagnostic Solomon" to determine whether these symptoms are clinical entities, or whether they are merely the result of a mental state? For instance, patients presenting the symptoms of a thyrotoxicosis may be suffering from this disease primarily or these symptoms be but the outward expression of inner emotional conflicts.

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3. Modern Treatment of Mental Disorders in German Hospitals. Prof. M. Weygandt. (The American Journal of Psychiatry. Volume X, No. 3. Nov., 1930).

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Dr. O. T. Avery, Rockefeller Institute Hospital, New York City, has been selected by the American College of Physicians as the recipient of the John Phillips Memorial Prize for 1932. This prize of $1500 is awarded annually by the college to perpetuate the memory of Dr. John Phillips, Cleveland. Dr. Avery was chosen to receive the award because of his outstanding studies upon the pneumococcus. The prize will be awarded to Dr. Avery at the Sixteenth Annual Clinical Session of the American College of Physicians, to be held in San Francisco the week of April 4.

The next written examination of the American Board of Obstetrics and Gynecology will be held in 19 different cities of the United States and Canada at 2 p. m. on Saturday, March 26, according to a recent announcement by Dr. Paul Titus, 1015 Highland Building, Pittsburgh, secretary of the board. Detailed information on the examinations may be obtained from Dr. Titus. The general, oral and clinical examination will be held in New Orleans, Tuesday, May 10, preceding the annual meeting of the American Medical Association.

Giragos Missak Churukian, graduate of the American University, Beirut, Syria, has been granted a license by the State Medical Board through reciprocity to practice medicine and surgery in Ohio. He will open offices in Cleveland.

Preventive Treatment, The Most Conservative Treatment

J. J. SUTTER, M.D., Lima, Ohio

ALL form of life has within it, a tendency to ward off, or to eliminate disease. This life force also has a tendency to correct defects, to make the crooked straight, and the abnormal normal; in other words, a body operating efficiently will frequently prevent the invasion of harmful micro-organisms, is relatively immune to disease and rarely succumbs when attacked by disease infection, or as Hippocrates said long ago, "The majority of diseases tend to correct themselves."

My experience has been that patients usually recover from the effects of their maladies when nature is given a chance and the natural forces of resistance are stimulated. We have all witnessed cases where patients apparently overcome by severe infection have made marvelous recoveries. The quotation, "Where there is life there is hope", so frequently heard in a sick room, is not an idle quotation. Most of us present today would be but memories if the balance of power would not be in favor of getting well and returning to normal, when one is sick or injured.

Close observing physicians have learned by experience that nature's methods must be utilized rather than overlooked in combating disease. It is logical to use all preventive methods available to aid nature's defense, for this will enhance the natural powers of resistance. To assist nature in the prevention of further dissolution or the advancement of the disease should first be instituted, then followed by means and methods which will aid in restoring to normal the abnormal by prescribing that which would have prevented the diseased condition. To find out just what would have prevented the ailment is as important as to know the immediate cause of it, for whatever will prevent an actuality will hold in abeyance a potentiality, or a possibility.

Physicians are giving more and more attention to preventive treatment. Books are being written on this subject and preventive medicine is taught in colleges in such a way that the newly graduated will have opportunities to serve in a larger way and with greater success than did the doctors of yesteryear.

Many diseases that were once thought inevitable are now known to be preventable. Today many of the preventable diseases are prevented. By prevention, we mean avoiding all sources of diseases and building up a high bodily resistance. Preventing diseases by improving the general health and raising the power of resistance to disease is more effective than the adoption of masks or the use of fumigants or disinfectants to kill germs, for germs are known to exist practically everywhere. Just recently it was reported, germs were found in the atmosphere by airplanes as high as one-half mile above the earth's surface.

I believe the best and most efficient defensive powers to fight germs and infection exist in the human body. Without question, our glands of internal secretion are designed to overcome abnormal conditions in the body tissues, but to explain how is not for me to say. The secret of nature, or of our resistance or our immunity, whichever you prefer, still remains the riddle of ages and a secret to the great body of the medical profession. We talk about it, but are not sure what it is. We do know, however, that this force, nature or body resistance is not a fixed quantity with any individual and that it may be increased or diminished.

"Whatever will prevent, will aid in a cure"', is a true saying and should be applied in the treatment of all disorders. If living in health will prevent much ill health, then a return to living in health will cure much ill health. The cure of a disease lies in arresting the disease process, or in preventing its further development and in aiding nature to restore the diseased organism to its normal function. The sixteen to one maxim—"An ounce of prevention is worth a pound of cure" expresses fairly accurately the comparative ratio of value between preventive treatment and curative medicine. There is no field of medicine, no specialty, in which the preventive treatment is not applicable.

Our cosmic surroundings in which we live, play an undeniable role in the state of our health. We are all aware that many diseases or disorders are brought into activity by the mode of life we live, or the kind of food we eat. Does not our growth, our health, and our life, as well as our desires, and our passions depend much upon our air, food, raiment and shelter? Faulty diet, without question, is a cause of many physical defects. The quotation, "Many people dig their graves with their teeth" is too true. Choosing the proper food will prevent much illness and will correct many defects. It is now realized that unless there is a proper ratio between the various kinds of foods, serious diseases may result. The body's needs—food, drink, rest, etc.—must be met, but never exceeded, if health is to be maintained or regained. The nerve depletion, to which many physicians and public men in the United States are subjected, is so severe that many suffer a premature death. Our American high office holders would live longer if their power of resistance would not be sapped by the numerous political campaignings, banqueting and high living.

Read before the Section on Public Health and Industrial Medicine, Ohio State Medical Association, at the 85th Annual Meeting, Toledo, May 12-13, 1931.

There are many disturbances due to faulty diet. Bad teeth, it is believed, are due to dietary deficiency. Calcium is readily mobilized from bones and teeth when needed for the regulation of mineral metabolism. By lowering the life power of a tooth or bony tissue, bacterial invasion is encouraged. Proper diet will prevent bad teeth and proper food is the essential factor leading to the arrest or cure of these conditions. We believe that diabetes, scurvy, pellagra, beri-beri, obesity, the anemias, goiter, rickets, with all its various bone deformities, softening of the bones in pregnancy, etc, are all due to the absence of certain elements or vitamins in the food. Each of these conditions can be prevented and will yield to treatment by a diet which would have prevented it, if given during the plastic age. All cases of goiter can be prevented if our economic conditions were correct and the iodine content in our food and water in right quantities. Rest and iodine will cure 87 per cent of all enlarged thyroids, we are told, but when destructive processes have entered the thyroid gland, an arrest of the process only can be expected by the preventive treatment. A cure needs the removal of the destructive process.

Pernicious anemia is treated most successfully by using that which would have prevented the disorder—that is, a mixed liver diet, liver of veal, beef and mutton. This will aid in bringing back the body fluid to normal. With sufficient amounts of liver or a potent liver extract, the hematologic picture of the uncomplicated cases becomes normal and the subjective symptoms disappear rapidly. Rickets and allied conditions are also treated along the line of prevention. Cod liver oil and sunlight will prevent rickets, so will it aid in a cure. In the treatment of diabetes, prevention is the conservative treatment. Insulin, or food containing insulin, will both prevent diabetes and stop its destructive process. Authorities agree that diabetics of all types can be restored to practically normal health and strength by diet alone, or with insulin as needed. Complications can be arrested if not already at a hopeless stage. Insulin, when prescribed in amounts sufficient to keep the blood sugar as nearly within normal limits as possible will prevent and cure a curable case of diabetes. And so, many diseases due to faulty diet can be cured by that which would have prevented them.

We prevent gall-stones, constipation, piles and and a host of other conditions by eliminating constantly all refuse from the alimentary canal. Parking of refuse in the alimentary canal is the cause of much human suffering. When the waste products of the body are improperly eliminated there always is a toxic lowering of resistance that invites infection of all kinds. Intestinal disorders, such as cholera, typhoid fever, diarrhea, dysentery, etc., should also be treated along the line of prevention. Whatever will prevent these conditions should be used in the treatment.

Many cases of Bright's disease, heart diseases and tuberculosis will yield to preventive measures. It is recognized that cure, in so far as restoration of anatomical and physiological function is concerned, is almost impossible when much mutilation has occurred. Each case is given a fair warning to keep on living a preventive treatment life to avoid further outbreaks, for if a patient relapses into the mode of life that brought on the disease, no matter what the name, the condition will recur. "If I had a peptic ulcer", someone said, "I would rather live a peptic ulcer preventive life, than have a bunch of teeth extracted that don't look just right on the *X*-ray film and go on living as before." Bad teeth and peptic ulcers are frequently due to the same cause. Whatever will arrest or prevent a peptic ulcer will do the same for a tooth.

It is true that the preventive treatment will not always prevent death. Where destructive processes have destroyed much of the live tissues, the element of time must not be overlooked, for time is extremely important in overcoming the disease process. If the corrected state can be maintained long enough to favor an elimination of the toxic agents and sufficient time is had for nature to heal all injuries, then death is prevented and life extended.

Other diseases or bodily defects are due to the inability to adjust to different environments. There are doubtless cosmic influences which act on the appearance of diseases, either by lessening the body resistance or by increasing the virulency of germs, for certain number of diseases appear only during certain periods of the year. A change of climate will prevent many respiratory diseases. A change of climate, job, altitude or position will aid in the cure of such conditions as asthma, hay fever, heart diseases, high blood pressure, nervous and emotional conditions. People living near or in the frigid zone have no fear of malaria or yellow fever, etc.

I have been in the harness of curative medicine and preventive medicine for a good many years, and I find that our greatest trouble is that we pay too much attention to anatomy and are not sufficiently acquainted with physiology. I have heard it said that we are like the postmen who know the names of all the streets of the town and the numbers of the houses, but do not know what is going on therein. It is more important for an internist to know the physiology than it is to know the anatomy of the organs of the body.

There are many drugs which will prevent diseases that are also used to stop the progress of a disease. Quinine will prevent malaria and quinine will cure malaria. Chalmoogra oil will both prevent and cure leprosy. Hepar sulphur will prevent boils and the formation of pus and will also aid in the cure of such conditions. Cascara will both prevent and cure constipation. Either chenopodium or carbon tetrachloride will aid in a

cure of hookworm disease. This remedy and adequate footgear sanitation will also prevent it. We believe when normal bile flows freely, gall-stones rarely form. Olive oil, or chionanthus will cause an increased flow of bile. Silver nitrate will prevent blindness in the new-born babe. This remedy is also used to treat ophthalmia. The use of insecticides or fungicides will prevent as well as eliminate insects. In every case the removal of as many of the offending parasites, bacteria and germs as possible without the destruction of healthy tissue is the first duty of the physician, then follow with the preventive medicines.

Inflammations are the result of infection which comes, either from without or from within the body. The body harbors staphyloccoci albus always, both inside and outside. Any injury or over-distention may become infected. An over-distended gall bladder or urinary bladder or an engorged bowel, appendix, breast, etc., frequently result in inflammation of the part affected. Prevention of over-distentions or the engorgement of organs will prevent inflammation. To restore the inflamed organs to their normal functions we must support the natural healing power of the organs and prevent further over-distention.

Again there are many foci of infection that must first be removed and then future foci prevented. The surgical removal of useless, dead or harmful tissue is aiding nature. The removal of an infected appendix, gall bladder, tonsil, or tooth, for example, is aiding nature. But we must not be deceived; the underlying cause of our sufferers is deeper than the focal infection. The prevention of focal infection is as important as the removal of the focal infections.

Many diseases can also be prevented by keeping the phagocytes busy and fully occupied in eradicating pathogenic bacteria. Since most germs enter the system through the respiratory organs, they should not be permitted to remain and multiply in these passages. We can aid nature by forcing these toxins into the blood stream. Compression of the nares or use of astringents will relieve the vascular stasis and force the infection into the blood stream, causing anti-bodies to be formed and the degree of immunity increased, thus avoiding many attacks of disease infection. By keeping the glandular system functioning properly, diseases are frequently prevented and arrested.

Again there are many physicians who have no hope for people who inherit a tendency to wasting diseases. Even if disease inheritance or a tendency for disease were true, it would not be such a serious thing. A tendency is just a little more than a potentiality and will remain dormant unless awakened or stirred up. There are many persons who have a tendency to be quarrelsome, but have learned not to allow themselves to foster this leaning, and thus prevent many quarrels. We likewise, can prevent many tendencies to disease to become an actuality. Whatever will prevent a tendency to become an actuality, will hold in abeyance a possibility.

DISCUSSION

H. J. POWELL, M.D., Bowling Green: I have known Dr. Sutter for a number of years. Ever since the Hughes-Griswold enactment was made a law we have been co-workers in public health; and in health work, I thought that we were of one accord, until I read his essay as presented in this program, which I have given several very careful readings and have analyzed every statement and have compared them with the writings of our very best thinkers. If this essay represents the author's articles of faith regarding his belief of preventive medicine, then, again we are in disagreement as we have been on occasions before. A biological fallacy is emphasized all through the paper from the very first sentence to the close.

The author says, (quoting from the first paragraph)—"All form of life has within it, a tendency to ward off, or to eliminate disease. This life force, also has a tendency to correct defects, to make the crooked straight, and the abnormal, normal."

Biologically this is a fallacy, a statement without proof. Every physician attending this meeting is aware of the fact that certain diseases are hereditary and inheritable, and as such remain fixed not subject to change. Among the conditions that are carried down from generation to generation may be mentioned migraine, deaf mutism, color blindness, astigmatism, fragile bones, cases of phalangeal ankylosis, food idiosyncrasies, polydactylism, blood groupings, hemophelia, family jaundice, hereditary ataxia, Huntington's chorea, epilepsy, psoriasis, ichthyosis, etc. Resistance to disease and longevity themselves are inheritable.

Is there a life force in any of the above cases that has a tendency to correct their defects, to make the crooked straight, or the abnormal, normal?

The author says, "Preventing disease by improving the general health and raising the power of resistance to disease is more effective than the adoption of masks or the use of fumigants, etc." Continuing he says, "I believe the best and most efficient defensive powers to fight germs and infections exist in the human body." Fallacy number two.

Public Health is a term which includes all knowledge and all measures tending to (a) foster health or (b) to prevent disease. Both these two objects are far from identical. The author would have us believe that high "general health" is essential in preventing disease. I could not accept such a statement if I knew it were true, for it smacks too much of Macfadden-ism which is the cornerstone of all propaganda circulated by the physical culture cult.

All public health workers are concerned with two factors (a) hygiene and (b) sanitation. Hygiene deals with the individual and his physical perfections, while Sanitation deals with the cause and source of those diseases which come from the outside, from the surroundings of the individual.

Physical perfection of an individual brought

about by careful attention to hygiene is not a stable condition, for we well know how easy it is to be upset by a chill, a missed meal, or fatigue; hence any protection offered by high health, if it really exists at all, is too vague and uncertain, too subject to sudden alterations and even complete loss, to be worthy of serious consideration as a real factor in the control of disease in ordinary life.

Therefore, what is ordinarily termed Preventive Medicine is to fortify the hygiene, the physiological functions of the individual—physical giant or muscular runt—by specific immunity against the inroads of specific infections from his environments. The greatest advance made, of recent years, in public health is the generalization from facts, long known in detail, that measures promoting bodily health and efficiency do *not* eliminate those external factors of disease by invasion from without.

"Many disturbances are due to our cosmic surroundings in which we live," says the author, and "play an undeniable role in the state of our health." In brief, granted sufficient exposure to infectious disease, the susceptible individual will succumb, though he live in a palace; the immune will escape though he be a physical runt and dwell in the slums. Far more practically important is the fact that the immunity is specific. The individual may be wholly immune to one disease and ultra susceptible to another, but such immunity or susceptibility has absolutely no relation to high health, robustness, or great vitality.

Moreover, public health as practiced today is not an economic proposition. When I read the statistical reports of any health department that tells me that in their particular state they have saved so many thousand lives, and actually have the temerity to put a money value on their work, I retort that I would like to look over the crowd and see whether they were worth saving and how long this saving process is likely to last.

The great physiological diseases of man's body —heart disease, Bright's disease, diabetes, cancer, degenerative diseases of the arteries, liver and central organs—are increasing; the functional neurosis, the diseases that effect man's mind and behavior,—neurasthenia, hysteria, epilepsy, insanity and multiform minor mental and nervous derangements of function—are all increasing; weaklings, paupers, hoboes and imbeciles are increasing; leadership and genius—great men and first class workmen—are decreasing.

Gentlemen, these statements are not mere daydreams, but facts that all thinking people must sooner or later face. I feel that every person dying under the age of twenty years, barring accidents, is an economic failure. Nature does not attempt to make the abnormal, normal, as our essayist would have us believe, but, to weed out the unfit if given a chance. But enormous sums of money are spent yearly in thwarting her efforts, yet in the long run progress must be established and nature gets her way. If by extra efforts the death rate is lowered by saving the unfit of the first year, nature will return and collect her extra toll the second year.

War is dysgenic and in the late World War millions of the fit were killed. While the A-1 men were sacrificing life and limb, the weaklings at home were propagating the race; but nature was not going to be thwarted all the time; she came along with a world-wide epidemic of influenza and wiped out more of the weaklings than the numbers of the fit killed in war.

In this discussion of Preventive Medicine we are told that "An ounce of prevention is worth a pound of cure." The author says, "Our cosmic surroundings in which we live, play an undeniable role in the state of our health", but he does not say a word about the conditions under which people are born. If you want an A-1 race you must breed them, there is no other way. You cannot take a set of runts, physical unfits and build them into giants by applying rules of hygiene and sanitation. You must apply genetics to the human race just as you do to the lower creation. If we want healthy children we must have them by choice and not by chance—which is the usual haphazard method in the present day.

Statistics can well be used to give emphasis to the problem that is facing us. Out of 45,000,000 children in the U. S.—

35,000,000 are reasonably normal; 6,000,000 are improperly nourished; 1,000,000 have defective teeth; 1,000,000 have weak hearts; 675,000 present behavior problems; 450,000 are mentally retarded; 382,000 are tubercular; 342,000 have impared hearing; 18,000 are totally deaf; 300,000 are crippled; 50,000 are partially blind; 14,000 are wholly blind; 200,000 are delinquent; 500,000 are dependent.

In 1930 there were, within the U. S., 16,000,000 children under the age of six. These children, constituting almost 13.5 per cent of the entire population of the country, in a short time will be found in our schools, and a little later, as adults, will take their places as citizens.

Up to two years of age, infant welfare centers are doing a most magnificent work in apparently improving the health of the nation's children, but it is lamentable that despite this, one quarter to one third of all children enter school physically unfit for education. What a black outlook for the nation with the above picture before us, together with several million unemployed and unemployable. If public health departments together with the public schools would get rid of their Lamarckian ideas, they might really do some good in their exalted position. If all maternity and child welfare centers were turned to proper use they might stop this manufacture of uneconomic beings who never have had and never can have much enjoyment in life. Then the fit in all classes of society would have a chance of doing something for the race instead of being taxed out of existence to support uneconomic wastrels.

There is no part of the animal economy more under hereditary influences than the circulation system. You get your health, physique, intellectual capacity and longevity—in fact the harmonious workings of your endocrine system, from your progenitors.

I know that there are many who agree with the author of the essay, that hold these Lamarckian ideas and tell us that all children are born healthy, that their potentiaility for life is equal, that their bad health depends on improper environments and poor food. To such that believe this doctrine, the Mendelian laws should be widely studied and carried out. They should take lessons from horticulturists and animal breeders. The nation that produces the finest and best race is sure to win in the long run, and when we get children with healthy circulatory systems, it will be the part of the health departments to tell and teach them how to keep them, not merely healthy but efficient to advanced age, but until that is accomplished, much misdirected energy will be lost.

The President's Page

A Personal Communication to the Membership from

D. C. Houser, M.D., Urbana, Ohio

Those who have kept themselves informed on numerous events and developments of the past few months surely must have been startled, as I have been, at the multiplicity of important and serious social, economic and governmental problems which have arisen to plague an already confused and bewildered society.

Quite naturally, I have found myself surveying and studying these complex and difficult questions in the light of their effect, or possible effect, on the practice of medicine, the medical profession, individually and collectively, and the health and welfare of the public.

The sudden changes which have already taken place in our entire social and governmental structure, and those which appear to be imminent, should not be considered lightly, but should be studied from the standpoint of their implications, possibilities and probable end-results.

Without intending to be in the least pessimistic, I believe that I may safely state that there never has been a time, at least during the lives of any of us now in practice, when the medical profession has been confronted by as many complicated and serious economic, social, governmental and legislative problems, many of which have a far-reaching effect on medical practice and public health.

The most crucial and dangerous period of this present cycle of change, unrest, evolution—call it what you will—is still to come, I believe. I refer to that time when there must be a definite "showdown", as it were, on the questions and issues which have been raised and on the panaceas and cure-alls now being concocted for the exploitation of an emotional and almost panic-stricken society.

Fraught as it has been, and is, with danger and disaster, the present period of unrest and change, in my opinion, should serve as an emphatic reminder to every member of the medical profession that the individual physician cannot live unto himself apart; cannot expect questions and problems of vital concern to him as an individual physician and to his profession to be satisfactorily solved unless he takes a personal and active interest in an organized effort to meet them.

Obviously, this leads one to the objects and benefits, the importance and value of medical organization which is the keystone in the professional, as well as the social and economic, life of the physician. In my President's Page comments last month, I called attention to a few of the benefits which each physician derives from membership in medical organization. It is not my intention to strike a harping attitude or to reiterate too often facts with which most of you are quite familiar, but I cannot at this time refrain from again emphasizing the importance and value to you, especially at this time, of continuous membership in your county medical society and the State Association. Due to present-day developments, this membership is perhaps more important, and relatively more valuable, to you now than ever before.

As has been pointed out on other occasions, membership in medical organization is an assurance of a physician's good standing in his community, before the public, the law and the profession. It is the strongest protection for physicians against exploitation, excessive socialization, destruction of professional relationships, and annoying and malicious attacks of various kinds. The physician who neglects to keep himself in good standing in medical organization places his professional standing in jeopardy and weakens the strength of the profession as an organized, militant and aggressive group.

Members are delinquent and in arrears in all their relations with medical organization, including medical defense benefits, from January 1 until the day on which dues are received at the State Association headquarters office. Furthermore, in compliance with federal postal regulations, the names of members in arrears must be removed from the mailing list of the *Ohio State Medical Journal* following the issuance of this —the March—issue. As I pointed out last month, no physician can afford to let a single month go by without reading carefully from cover to cover *The Journal*. The detailed program and announcements for the Eighty-Sixth Annual Meeting of the State Association, to be held at Dayton, May 3 and 4, will be published in the April issue and physicians in arrears with their dues will not have the opportunity of knowing in advance of the splendid treat in store for members of the State Association who attend the Dayton meeting.

Speaking of the Annual Meeting, it is my personal opinion that one of the best scientific programs ever formulated for a meeting of the State Association has been arranged for presentation at this year's gathering. The Council Program Committee and the sectional officers have spared no time and effort to assemble much of the very best of Ohio's fine array of medical talent for the forthcoming meeting. I am sure every physician who is privileged to attend the Dayton meeting will be abundantly repaid for doing so.

Hotel Reservations for 86th Annual Meeting of the State Association in Dayton Should Be Made Promptly

Hotel reservations should be made as promptly as possible by Ohio physicians who are contemplating attending the Eighty-Sixth Annual Meeting of the Ohio State Medical Association at Dayton, Tuesday and Wednesday, May 3 and 4. The golf tournament and clinics will be held on Monday, May 2.

Requests for hotel reservations should be made direct to the hotel selected and verification should be requested.

The Dayton-Biltmore has been selected as the headquarters hotel. It will house the commercial and scientific exhibits and the registration headquarters, and will be the meeting place for the general sessions and most of the scientific sections.

Meetings not held at the Dayton-Biltmore will be held at the Miami Hotel, a short distance from the Biltmore.

Dayton is liberally supplied with hotels but in order to secure good accommodations readily accessible to the annual meeting hotels, physicians who are intending to attend the gathering are urged not to delay in making their reservations.

The Dayton Chamber of Commerce, which is cooperating with the Montgomery County Medical Society in making local arrangements for the Annual Meeting, has furnished the following list of Dayton hotels, their rates and conveniences for the information of physicians expecting to be at the meeting.

DAYTON-BILTMORE

Headquarters Hotel

Corner of First and Main Streets, 600 rooms; single room, lavoratory and toilet, $2.50; single room, with bath, $3.00 up; single room, combination tub and shower, $3.50, $4.00 and $5.00; double room, with bath, $5.00; double room, combination tub and shower, $6.00, $7.00, $8.00 and $9.00; suites, $9.00 up; double rooms occupied by three persons $2.00 additional; garage adjoining hotel.

MIAMI HOTEL

Second and Ludlow Streets, (where some of the section sessions will be held), 350 rooms; single room with bath, $3.00 up; double room with shower, $5.00 up; double room with tub bath, $5.00 up; room with twin beds, $6.00 up; suite, $15.00 up.

VAN CLEVE HOTEL

First and Ludlow Streets, 150 rooms; single room with bath, $3.00 up; double room with shower, $5.00 up; double room with tub bath, $5.00 up; room with twin beds, $6.00; suite, $15.00.

GIBBONS HOTEL

Third and Ludlow Streets, 250 rooms; single room with bath, $2.50; double room with shower, $5.00 up; double room with tub bath, $5.00; room with twin beds, $4.00; suite, $6.00 up; single room with tub and shower, $3.00; double room, tub and shower, $5.00.

MORAINE HOTEL

Ludlow near Third, 150 rooms; single room with bath, $2.50; room with twin beds, $3.00; suite, $7.00.

Beckel Hotel

Third and Jefferson Streets, 300 rooms; single room with bath, $2.00 up; double room with tub bath, $2.50 up; room with twin beds, $1.50 up; suite, $5.00.

Colonial Hotel

Fifth near Wilkinson, 100 rooms; double room with tub bath, $3.50; room with twin beds, $3.50; suite, $5.00; single room without bath, $1.50 up; double room without bath, $3.00.

Holden Hotel

Fifth and Wilkinson Streets, 100 rooms; single room with bath, $2.50; single room without bath, $1.75; single room tub and shower bath, $3.00; double room with shower bath, $4.50; double room, tub and shower bath, $5.00; room with twin beds, $5.00.

Haynes Hotel

Third and Ludlow Streets, 50 rooms; single room with bath, $2.00 up; double room with tub bath, $3.50 up; room with twin beds, $3.00.

Ohio Hotel

Fifth near Wilkinson, 35 rooms; single room with bath, $2.00; double room with tub bath, $3.00; room with twin beds, $3.00.

Three Ohio physicians were honored by being elected to office at the recent meeting in Pittsburgh of the Tri-State District, American College of Surgeons. Dr. E. R. Arn, Dayton, was elected counselor for Ohio; Dr. John H. Weber, Akron, was named chairman of the Ohio section, and Dr. Paul E. Greenawalt, Springfield, secretary of the Ohio section.

According to a recent announcement in the *Journal of Medicine,* Cincinnati, the executive faculty of the College of Medicine, University of Cincinnati, has voted that beginning with 1934 a student before filing an application for admittance to the College of Medicine must have had three years of collegiate work.

Several Important Amendments to the Constitution and By-Laws of the State Association Proposed for Consideration By the House of Delegates at the Annual Meeting In Dayton, May 3 and 4.

Several proposals have been made for amendments to the Constitution and By-Laws of the Ohio State Medical Association. Pursuant to the requirement for publication in the *Ohio State Medical Journal* prior to action by the House of Delegates of the State Association at the next Annual Meeting in Dayton, Tuesday and Wednesday, May 3 and 4, 1932, the proposals are set forth below.

PROPOSED AMENDMENT No. 1

The following resolution proposing amendments both to the Constitution and By-Laws, to enlarge the Council of the State Association by the election of four Councilors-at-large is proposed by Dr. C. L. Cummer, Cleveland, Chairman of the Council Committee on Constitutional Conformity. In submitting the following proposal, Dr. Cummer points out that the medical profession is facing the most difficult period in its history with marked changes in the economic relationship between physician and patient, and that it is especially important at this time to avail ourselves of the best counsel and thought which can be obtained within our own ranks:

* * *

Resolved that Article VII of the Constitution be amended by striking out Sections 1 and 4 and substituting for them the following sections respectively:—

Section 1. OFFICERS. The officers of this Association shall be a President, a President-elect, the Past President, a Treasurer, ten District Councilors and four Councilors-at-large.

Section 4. TERM OF OFFICE. The President shall serve one year and shall be succeeded by the President-elect. The Treasurer shall be elected for a term of three years. The term of office of the Councilors shall be two years; five District Councilors and two Councilors-at-large shall be elected each year. All these officers shall serve until their successors are elected and qualified. At the annual meeting in 1932, four Councilors-at-large shall be chosen, two to serve for two years and two for one year.

* * *

Resolved that Chapter VI, Section 1, of the By-Laws be amended by inserting the word "District" before the word "Councilor" in the last sentence, so that this sentence will read as follows:—

"Each nominee for District Councilor must be a resident of the district for which he is nominated."

Also resolved that Chapter VI, Section 1, be further amended by adding the following additional sentence at the end of the Section:—

"No more than one Councilor-at-large shall be elected from any one district."

Resolved that Chapter VIII, Section 2, of the By-Laws be amended by inserting the word "District" before the word "Councilor" in the first sentence, to make this sentence read as follows:—

"Each District Councilor shall be the organizer, peacemaker and censor of his district."

Also resolved that Chapter VIII, Section 2, be amended further by adding the following sentence at the end, of the section, to-wit:—

"The duties of the Councilor-at-large shall be such as would naturally devolve upon the members of the Council, but they shall not be responsible for the field work in the districts herein specifically assigned to the District Councilors."

Resolved: that these Amendments to the Constitution and By-Laws become effective immediately upon adoption.

PROPOSED AMENDMENT No. 2

The following proposed amendment by Dr. John A. Caldwell, is submitted by Dr. S. J. Goodman, as Secretary of the Council, pursuant to action taken by the Council at its meeting on December 13, 1931 (Pages 55 and 56 of the January, 1932, issue of *The Journal*). The following proposed

amendments were recommended in discussion by the Council with the idea of providing more flexibility from time to time in the scientific program, and for more ready adjustment to the wishes of the membership for presentations on interesting and timely subjects:

* * *

Resolved that Chapter III of the By-Laws of the Ohio State Medical Association be repealed and in lieu thereof the following be enacted:

CHAPTER III

Section 1. SCIENTIFIC PROGRAM. The Scientific Assembly shall meet in one or more general sessions during each Annual Meeting, as determined by the Program Committee of Council upon approval by Council. The Scientific Assembly shall also be divided by the Council into sections for each annual meeting.

Sec. 2. SCIENTIFIC SUBJECTS. In arranging for Section meetings, the Council shall have in mind the divisions of medicine, surgery, gynecology, obstetrics, pediatrics, eye, ear, nose and throat, neurology, psychiatry, public health, preventive medicine, and industrial medicine; and such other special fields of medicine as it may determine from time to time.

Sec. 3. SECTION OFFICERS. Each Section shall elect a chairman and a secretary to serve for the ensuing year. They shall constitute its program committee. In case a Section has not met at the preceding annual meeting or has been newly organized, or for any other reason has not elected its officers, then such officers shall be appointed by the Council.

Sec. 4. SECTION SESSIONS. Each Section shall hold its session or sessions at such time as the Council shall direct, but no more than six Sections shall meet at the same time, nor shall any Section session be allowed to conflict with a general session.

Sec. 5. TITLE OF PAPERS. No paper shall be presented before a section unless the title and an abstract which shall contain not less than thirty nor more than one hundred and fifty words is in the hands of the Program Committee at least sixty days before the first day of the annual meeting.

Sec. 6. SECTION RULES. The discussions in Sections shall be limited to scientific subjects. Rules adopted by Sections shall be subject to approval by the Council and shall not be in conflict with the Constitution and By-Laws of this Association.

PROPOSED AMENDMENT No. 3

Dr. D. C. Houser, the President, submits for the consideration of the House of Delegates at the 1932 Annual Meeting, a proposed amendment to Section 1 of Article XI of the Constitution to provide for publication in *The Journal* of proposed amendments to the Constitution *"at least"* two months before the annual meeting and require such proposed amendments to be sent officially to each component county society at least *"one month"* instead of *"two months"* before the annual meeting at which they are to be acted upon by the House of Delegates.

Dr. Houser's proposed amendment would, therefore, make this section read as follows, with the new words in italics and the omitted words in parenthesis:

* * *

ARTICLE XI

Section 1. AMENDMENTS. The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates and officers registered at that annual meeting, provided that such amendment shall have been published in *The Journal* of this Association *at least* two months before the annual meeting, and that it shall have been sent officially to each component county society at least *one month* (two months) before the annual meeting at which final action is to be taken.

PROPOSED AMENDMENT No. 4

Dr. Houser also proposes an amendment to Section 4, Chapter V of the By-Laws to make it conform to Section 4, Chapter VIII of the By-Laws, providing that questions of an ethical nature brought before the House of Delegates shall be referred to the Council without discussion.

This proposed amendment, with the newly suggested material in italics and the omitted material in parenthesis, would make Section 4 of Chapter V of the By-Laws read as follows:

* * *

Section 4. COMMITTEES OF THE HOUSE OF DELEGATES. From among members of the House of Delegates the President, for the purpose of expediting proceedings, shall appoint Reference Committees as follows: On Annual Reports; on (President's address) *Annual Addresses;* on Resolutions; to which shall be referred all resolutions introduced into the House of Delegates (*except questions of an ethical nature involving professional relations*

which shall be referred to the Council without discussion); a Committee on Credentials; Tellers, and Judges of Election, and other committees considered by him to be necessary.

PROPOSED AMENDMENT No. 5

In order to provide uniformity in the selection of delegates and legislative committeemen at the annual meeting of the component county societies at the same time other officers are elected, Dr. Houser, the President, proposes the following amendments to Section 12 and Section 14, respectively, of Chapter XII of the By-Laws, showing the new material in italics and the present material proposed to be eliminated in parenthesis as follows:

* * *

Sec. 12. CERTIFICATION OF DELEGATES. *At the regular annual meeting of each component county society, it* (At some meeting in advance of the annual meeting of this Association, each component county society) shall elect delegates to represent it in the House of Delegates of this Association, in accordance with Chapter V, Section 2, of these By-Laws, *unless other definite procedure for the selection of delegates is provided in the Constitution and By-Laws of such component county society or academy of medicine.* The secretary of each county society shall send a list of such delegates and alternates to the Executive Secretary of this Association at least thirty days before the annual meeting. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions. In the absence of, or the disability or disqualifying of a delegate, his duly certified alternate may be seated in his place.

* * *

Sec. 14. AUXILIARY LEGISLATIVE COMMITTEE. *At the regular annual meeting of each component county society, it shall elect* (Each component society shall appoint or elect) one of its members as a member of the auxiliary committee on Public Policy, *unless other definite procedure for the selection of such committeeman is provided in the Constitution and By-Laws of such component county society or academy of medicine,* and the county society secretary shall send his name and address at once to the Executive Secretary of The Ohio State Medical Association. The committee on Public Policy of The Ohio State Medical Association shall formulate the duties of this auxiliary committee and supply each member with a copy. The auxiliary committeemen shall be accountable to their county societies and to the Council of The Ohio State Medical Association for prompt response to and continued cooperation with the State Association Committee on Public Policy.

PROPOSED AMENDMENT No. 6

Under the action by the House of Delegates at the last Annual Meeting in regard to Resolution H, introduced by Dr. H. C. King of Cleveland (Pages 474 and 482 of the June, 1931, issue of the *Ohio State Medical Journal),* the following proposed amendment is submitted for the consideration of the House of Delegates at the 1932 Annual Meeting, which, if adopted, would repeal from the present By-Laws the membership requirement for citizenship:

* * *

Resolved that the paragraph "(a)" in Section 4 of Chapter I of the By-Laws of the State Association be repealed and which at present reads as follows:

"(a) He must be a citizen of the United States or must have declared his intention of becoming a citizen by filing first citizenship papers with the United States Government."

And be it further resolved that paragraphs "(b)" and "(c)" be renumbered as "(a)" and "(b)" respectively.

Dr. Elliott C. Cutler, director of surgery, Lakeside Hospital, Cleveland, and head of the Department of Surgery, Western Reserve University, School of Medicine, has accepted the position as surgeon-in-chief of Peter Bent Brigham Hospital, Boston, and Mosely professor of surgery at Harvard Medical School. He will assume his new duties September 1. Dr. Cutler will succeed Dr. Harvey Cushing, formerly of Cleveland, who is retiring. Dr. Cutler, who is 43 years of age, graduated from Harvard in 1909. In 1915, Dr. Cutler was appointed head of the Harvard Unit with the American Ambulance Service in France. After serving overseas, Dr. Cutler became resident surgeon at the Massachusetts General Hospital and alumni assistant in surgery at Harvard. When America entered the World War, he was commissioned a captain and later promoted to major, serving as head of Base Hospital No. 6 in France. He was awarded the Distinguished Service Medal for his service overseas. Before coming to Cleveland eight years ago, Dr. Cutler was on the faculty at Harvard and associated with the Brigham Hospital to which he is returning.

State Conference on Child Health and Protection in Columbus Draws Large Attendance

More than 1,000 persons interested in health and social problems affecting the children of Ohio attended the Ohio Follow-Up to the White House Conference on Child Health and Protection, held in Columbus, January 21 and 22, at the Deshler-Wallick Hotel.

The conference was called by Governor George White for the discussion of child health and social problems in this state and to effect a program for carrying out in Ohio some of the recommendations made by the Washington conference called by President Hoover.

A varied and interesting program for the two-days meeting was arranged by an executive committee named by Governor White to arrange for the conference and composed of A. C. Crouse, Cincinnati, former secretary to the Governor, chairman, Dr. H. G. Southard, State Director of Health; John McSweeney, State Director of Public Welfare; B. O. Skinner, State Director of Education, and Miss Hannah L. Protzman, Columbus, secretary.

At a preliminary session of the conference, held on the morning of January 21, members of the executive committee addressed a large gathering of health, social service and welfare workers, outlining the purposes of the conference and pledging the cooperation and support of their respective department in whatever program the conference might formulate.

Governor White opened the conference proper on the afternoon of January 21, with an address reviewing the work of the White House Conferences which had been called by President Roosevelt, President Wilson and President Hoover, and offering his support to any plans the conference might make for solving child health and social problems in Ohio.

A symposium on "The Child's Home Setting" was then presented, the speakers being: Dr. A. Graeme Mitchell, professor of pediatrics, University of Cincinnati, who spoke on "Ushering the Child Into the Home"; Dr. T. Wingate Todd, professor of anatomy, Western Reserve University, on "Growth and Development"; Mrs. C. M. Lotspeich, director of the Lotspeich School, Cincinnati, on "Character Building" and Miss Emma C. Puschner, director of the National Child Welfare Division, The American Legion, Indianapolis, who summarized the remarks made by the previous speakers.

A public mass meeting held that evening at Memorial Hall was addressed by Rabbi Abba Hillel Silver, Cleveland, who reviewed and emphasized problems relating to providing proper ways for the child to utilize the additional leisure time developed by the machine age and the unemployment question.

On the morning of January 22, a symposium on "The Child's School Setting" was presented by Dr. Charles S. Berry, director of the Bureau of Special Education, Ohio State University; Dr. D. Oberteuffer, supervisor of health and physical education, State Department of Education; Dr. E. B. Bryan, president of Ohio University, Athens, and Dr. George F. Arps, dean of the College of Education, Ohio State University. Dr. Berry spoke on "Adventures of the Mind"; Dr. Oberteuffer on "Adventures of the Body"; Dr. Bryan on "Adventures of the Character", and Dr. Arps summarized the previous comments.

On the afternoon of that day, a symposium on "The Child's Community Setting" was given by Dr. Henry Busch, assistant director of the Cleveland College, Cleveland, who spoke on "Lure of Skill"; A. E. Roberts, scout executive, Boy Scouts of America, Cincinnati, on "Companionships"; Arthur E. Morgan, president of Antioch College, Yellow Springs, on "Triumph Over Inevitables", and Dr. Henry Schumacher, Cleveland, who presented the summary.

The closing session of the conference was a banquet on the evening of January 22, attended by Governor White and addressed by C. M. Bookman, president of the National Conference of Social Work, Cincinnati.

Following Mr. Bookman's address, Miss Protzman, reporting for a special committee named earlier in the session to select local and state organizations to be represented on a state committee to formulate a program for Ohio and cooperate with local units in cordinating all work in child health and protection, announced that the committee was not perpared as yet to announce the names of organizations selected, but that it hoped within the next few weeks to have compiled a complete list of organizations and agencies. These groups will be asked to name representatives on the central committee which will then undertake the formation of a tangible program to stimulate activity throughout the state in the questions discussed by the conference. Dr. J. H. J. Upham, dean of the College of Medicine, Ohio State University, is a member of the committee undertaking the selection of the groups which will be requested to name representatives to the permanent state-wide committee.

Five days have been cut from the time required to start payment on routine claims filed with the State Industrial Commission during the past year, Thomas A. Edmondson, director of the State Department of Industrial Relations, announced recently. Mr. Edmonson said that routine claims now require 6.61 days before a check is issued, as compared to 11.61 days a year ago.

Medical Relief to Indigents—Responsibility of Government Units for Payment—Statutes Quoted and Construed —Distinctions and Definitions Noted

Administration of poor relief by townships, counties and municipalities has become one of the important functions of these political subdivisions during the past few months because of the numerous demands for various kinds of relief from individuals and families whose finances have been depleted because of current business and unemployment conditions.

Many new problems in the distribution of poor relief have arisen, ranging from problems of securing necessary funds for the work, to the need for clarification of the statutes relating to poor relief through legal interpretations and court decisions.

Supplying indigents with medical service and hospital care always has been one of the major phases of poor relief. This problem has become acute in many communities. Heavy demands have been made on public officials and practically every physician in the state has noted a substantial increase in the number of charity patients, or patients able to pay but a portion of the regular and customary fees for various kinds of medical service.

Because of the abnormally heavy charity load which many physicians have been compelled to carry, they have been forced to look more and more to townships, counties and cities for compensation for services to individuals who are entitled to poor relief.

As a result, some confusing and complex problems, and occasionally misunderstandings, have arisen between the medical profession and public officials in charge of poor relief work. In some localities, administration of medical care to the poor has functioned smoothly because of cordial and cooperative relationship between the medical profession and public officials. In others, the converse is true because physicians and these officials have made no effort to arrive at a mutual understanding of common problems or to work out a program satisfactory to all parties.

In some instances, confusion has occurred because of the lack of a clear understanding on the part of physicians of the provisions or intent of Ohio laws relating to poor relief and what the duties and responsibilities of the physician are under these statutes.

For the information of physicians generally, some of the statutes on poor relief as they apply to medical and hospital services, etc., are summarized in succeeding paragraphs of this article.

"LEGAL SETTLEMENT" DEFINED

One of the first questions which arise in administration of the poor laws is that concerning "legal settlement"; that is, the legal resident of the person requiring relief. This must be determined before the political subdivision responsible for furnishing relief can be determined. The following sections of the General Code deal with the matter of "legal settlement":

3477. Legal settlement defined—Each person shall be considered to have obtained a legal settlement in any county in this state in which he or she has continuously resided and supported himself or herself for twelve consecutive months, without relief under the provisions of law for the relief of the poor, or relief from any charitable organization or other benevolent association which investigates and keeps a record of facts relating to persons who receive or apply for relief.

3478. Defense of trustees in action for nonsupport of pauper.—In an action to compel the support or relief of a pauper, or in an action based upon the refusal of such officers to afford support or relief to any person, it shall be a sufficient defense for the township trustees, or proper municipal officers to show that such person, during the period necessary to obtain a legal settlement therein has been supported in whole or in part by others with the intention to thereby make such person a charge upon such township or municipal corporation. The fact that such person, during the period necessary to obtain a legal settlement therein, has been supported in whole or in part by others shall be prima facie evidence of such intention.

3479. Who considered to have legal settlement.—A person having a legal settlement in any county in the state shall be considered as having a legal settlement in the township, or municipal corporation therein, in which he has last resided continuously and supported himself for three consecutive months without relief, under the provisions of law for the relief of the poor, or from any charitable organization or other benevolent association which investigates and keeps a record of facts relating to persons who receive or apply for relief. When a person has for a period of more than one year not secured a legal settlement in any county, township or city in the state, he shall be deemed to have a legal settlement in the county, township or city where he last has such settlement.

WHO SHALL FURNISH RELIEF

Poor relief may be furnished by the county, the township or a municipality depending on the "legal settlement" of the individual requiring relief.

Which subdivision has jurisdiction in each particular case is specified in *Section 3476* of the General Code, which reads as follows:

3476. Trustees and municipal officers shall afford relief. —Subject to the conditions, provisions and limitations herein, the trustees of each township or the proper officers of each city therein, respectively, shall afford at the expense of such township or municipal corporation public support or relief to all persons therein who are in condition requiring it. It is the intent of this act that townships and cities shall furnish relief in their homes to all persons needing temporary or partial relief who are residents of the state, county and township or city as described in Sections 3477 and 3479. Relief to be granted by the county shall be given to those persons who do not have the necessary residence requirements, and to those who are permanently disabled or have become paupers, and to such other persons whose peculiar condition is such they cannot be satisfactorily cared for except at the county infirmary or under county control. When a city is located within one or more townships, such temporary relief shall be given only by the proper municipal officers, and in such cases the jurisdiction of the township trustees shall be limited to persons who reside outside of such a city.

As provided in the foregoing section, the agency responsible for carrying on poor relief work in the township is the board of township trustees.

Care of the sick poor of a municipality is primarily the function of the municipal board of health or board of health having jurisdiction in the municipality. This is provided in *Section 4410*, General Code, of the statutes outlining the duties of a city board of health, as follows:

4410. Care of the sick poor and quarantined persons.—The board of health shall care for the sick poor and each person quarantined when such person is unable to pay for care and treatment, and for all persons sent to the municipal detention hospital when such persons are unable to pay for care and treatment.

The function of a county in furnishing poor relief differs from that of a township or municipality.

As provided in *Section 3476*, the county is authorized to furnish poor relief to persons who do not have necessary residence requirements of any township or city within the county; to those who are permanently disabled or have become paupers, and to persons whose peculiar condition is such that they cannot be satisfactorily cared for except in a county infirmary or under county control.

Section 2544 authorizes the county to maintain a county home and *Section 2546* authorizes the county to contract with one or more physicians to furnish medical relief to inmates of the county home but specifically states that no medical relief shall be furnished by the county for persons in their own homes except for persons who are not legal residents of the state or county for one year, or residents of a township or a city in the county for three months.

A county also is financially responsible for medical and hospital care rendered a person having legal settlement there by a political subdivision in another county. The mechanics for adjusting the compensation in such cases between the county of legal settlement and any of the subdivisions of the other county are provided in *Sections 3481, 3482, 3483, 3484, 3484-1, 3484-2 and 4438*, General Code.

Sections 4438-1 and 3480-1 provide the means whereby townships and municipalities may be reinbursed from another township or municipality in the same county for medical and hospital services furnished an indigent whose legal settlement is in the other township or municipality.

TWO METHODS PROVIDED

Townships and municipalities have the choice of two methods for furnishing medical care to the indigent sick. Under the provision of *Section 3490* the trustees of a township or the proper officers of a municipal corporation may contract with one or more competent physicians to furnish medical relief to persons who come under their charge under the poor laws. Some townships and cities have adopted this method of caring for the sick poor who have legal settlement in the township or city.

In the great majority of townships and cities, however, medical care to the sick poor is rendered by physicians not under contract and who look to the township or city for remuneration for services rendered.

It is under this method of furnishing medical relief to the poor that most of the misunderstandings between public officials and the medical profession arise.

MUST NOTIFY TRUSTEES

The mechanics for obtaining medical relief from township trustees or municipal officials and how a physician shall proceed to obtain compensation for services to the needy poor are provided for in *Section 3480*, General Code, as follows:

3480. Relief, how obtained; notice to trustees or officers.—When a person in a township or municipal corporation requires public relief, or the services of a physician or surgeon, complaint thereof shall be forthwith made by a person having knowledge of the fact to the township trustees, or proper municipal officer. If medical services are required, and no physician or surgeon is regularly employed by contract to furnish medical attendance to such poor, the physician called or attending shall immediately notify such trustees or officers, in writing, that he is attending such person, and thereupon the township or municipal corporation shall be liable for relief and services thereafter rendered such person, in such amount as such trustees or proper officers determine to be just and reasonable. If such notice be not given within three days after such relief is afforded or services begin, the township or municipal corporation shall be liable only for relief or services rendered after notice has been given. Such trustees or officer, at any time may order the discontinuance of such services, and shall not be liable for services or relief thereafter rendered.

It is mandatory under this section that a physician attending a person entitled to relief under the poor laws shall notify the township trustees or municipal authorities within three days after medical care is given or such services begin in order to obtain compensation for his services.

Obviously, in some instances physicians have been put to considerable difficulty to notify the proper officials in writing within the three-day limitation. In some communities, this provision has been liberally construed by township and municipal officials, especially when it has been possible for the physician rendering service to explain why a delay in notification was unavoidable.

PROBLEM OF MEDICAL FEES

Another question which occasionally arises in administration of the poor laws with regard to medical services is that of the payment of adequate fees for medical service to indigents. Under *Section 3480*, townships and municipalities are empowered to pay for medical services "in such amount as such trustees or proper officers determine to be just and reasonable".

In some parts of the state, physicians have had considerable difficulty in securing adequate payment for service rendered under the poor laws, due to an unsympathetic attitude on the part of township trustees or city officials, or to their lack of a realization of what is adequate compensation for various types of medical service.

Some county medical societies have rendered their members valuable service in this connection

by holding conferences with township and municipal officials at which the questions of fees and other problems having to do with the poor laws have been discussed and a proper understanding reached as to the responsibilities of public officials, not only to indigent persons requiring medical service, but to the physicians rendering such service. In most of the counties where a spirit of understanding and cooperation has been developed by effective and concerted effort on the part of the local medical profession, little difficulty and misunderstanding regarding fees and other functions of both officials and physicians have resulted.

Any effort to have written into the law a definite fee schedule or a reference to any existing fee schedule has always been discouraged by the Committee on Public Policy of the State Association. That committee has been of the opinion that, if such a fee schedule should be adopted by law, the public generally might feel that those were the standard legal fees for various types of medical services. Also, that such enactment might eventually result in legal involutions of an undesirable and embarrassing nature.

The question is largely one of local administration and local determination, the Committee believes, and one which probably can be solved through the development of a proper understanding between the local medical profession and the public officials responsible.

ATTORNEY GENERAL OPINIONS

A number of interesting and enlightening opinions, interpreting the statutes relating to medical and hospital services for the poor, have been rendered during the past year by Attorney General Gilbert Bettman of Ohio. Several of these opinions follow in part:

Opinion No. 3605 on this question was given to the prosecuting attorney of Preble County in the following case:

Mr. J. C. and his family moved from an adjoining county to Jefferson Township in Preble County. Three weeks later the daughter of J. C. became seriously ill. Immediate hospitalization to save the child's life was ordered by the attending physician. Since the family was penniless, the matter was referred to the township trustees. The nearest hospital facilities were at Richmond, Indiana, so the child was ordered taken there for treatment. The question raised was whether Jefferson Township or the adjoining county,—still the place of legal residence of the family—should pay the bill for medical and hospital services rendered.

Mr. Bettman quoted *Section 3483-2*, General Code, explaining that the section contains nothing which requires that the medical services or hospital service for indigents must be furnished by a doctor or a hospital located within the state of Ohio, and that a reasonable interpretation of the section would require that such medical services or such services of a hospital be furnished by a doctor or a hospital situated near the person to be treated, and it would be unreasonable to incur a greater expense in transporting such patient to a doctor or a hospital located at a greater distance, if a suitable doctor or hospital in near at hand and available.

Since the facts in the instant case indicated there was urgent need for immediate hospitalization and medical attention; that there were no adequate hospital facilities within the township, and that the nearest hospital was the one to which the child was sent, Mr. Bettman held that the expenses of hospitalization in the Richmond, Indiana, institution, should be paid by the township trustees and certified to the county of legal residence for reimbursement.

Summing up his interpretation of the statutes governing the case, Mr. Bettman said:

"Since there is no language in the section under consideration *(Section 3483-2)* which requires hospitalization and medical attention to be furnished by hospitals or doctors resident or located within the state of Ohio, and keeping in mind the fact that the main purpose of this section is the rendering of medical and hospital attention to indigent persons, I am of the opinion that upon compliance with the provisions of *Section 3483-2*, hospital and medical expenses for services rendered by a township in the treatment of an indigent person resident of another county are charges upon such county, and the fact that such hospital or medical services were furnished by a doctor or hospital located in another state does not bar recovery by the township rendering such services from the county of the residence of the indigent person to whom such services were rendered."

* * *

A similar question was analyzed in Opinion No. 3726, rendered to the prosecuting attorney of Logan County in answer to an inquiry concerning the payment of medical services in a confinement case, the woman being indigent but not a legal resident of the county nor of the township in which the confinement took place.

Mr. Bettman pointed to *Section 3480*, General Code, as the governing statute in the case. This section was quoted in full in preceding sections of this article.

"In analyzing the above section," Mr. Bettman stated, "together with its related sections, it would appear that it does not take into consideration the question of residence or legal settlement of the person who is ill and in need of a physician or surgeon. At least when emergency cases such as described are involved, it is evident that the delay in determining the residence of the patient, or the delay in working out the relative liability of the political subdivision can not be countenanced. Humanity, in such cases, requires

relief to be promptly furnished. It will therefore appear that the municipal officers or township trustees are to furnish such relief in the matter provided by *Section 3480*, supra."

Concerning the method whereby subdivisions furnishing such relief may be reimbursed for such expenditures, Mr. Bettman referred to *Sections 3480-1 and 3484-2* which, he held, specify that the subdivision furnishing medical services for an indigent may be reimbursed from the county in which such person has a legal settlement.

* * *

Another ruling (Opinion 3325) of Mr. Bettman's deals with similar questions and also the question of payment of a physician under contract by a township for medical services rendered an indigent person at the request of an adjoining township.

The facts in this case were:

One of the townships of Clinton County has a contract with a physician to take care of the indigent sick under *Section 3490*, General Code. A person moved from this township into an adjoining township. While living in the second township, he became ill and the trustees of the second township called upon the physician who was under contract with the first township to treat him. The trustees of the second township intended to pay the physician from their township funds, but upon investigating, found that the patient was still a legal charge upon the first township, and notified the first township within the statutory time of the services rendered. The question then arose: Is the first township which had the physician under contract liable for payment for the services he rendered the patient at the request of the second township?

Mr. Bettman in his opinion held that medical services requested by the trustees of a township for an indigent person whose legal settlement in another township in the same county should be paid by the township requesting such medical service and charged to the township of legal settlement, as provided in *Section 3480-1*, General Code; that in the case at issue it was a mere coincidence that the township chanced to call the physician under contract with the township of legal settlement, and that this should not act as a bar to prevent the physician from receiving compensation for his services.

* * *

Opinion 3199 handed down by Mr. Bettman is pertinent since it deals with services rendered by physicians at the request of a board of education and the question of the agency responsible for compensating the physicians for their services.

The questions arose after a board of education having jurisdiction over several townships ordered all children attending schools in the townships vaccinated before entering school and a number of indigent children had been vaccinated by local physicians, some of whom tendered bills to the board of education and others to the trustees of the various townships.

Mr. Bettman held that under *Section 7686*, General Code, which deals with the powers of the board of education in the vaccination of children, requires that board of education make an application to the board of township trustees for means of smallpox vaccination before such cost may be charged against the township.

He also cited *Section 3480*, General Code, relating to township poor relief generally, which requires a notice of the furnishing of medical relief to be given the township trustees within three days after the rendition of the services.

Mr. Bettman held that unless one or the other of these provisions was complied with the township trustees could not be held liable for payment for the medical services.

The attorney general further held that in his opinion the board of education under the provision of *Section 7692-1*, General Code, which authorizes the board to employ school physicians to make examinations and diagnoses, would not be authorized to furnish medical relief such as vaccination for smallpox.

Mr. Bettman in another opinion (Opinion No. 3539) in answer to a question as to the liability of a board of education for medical services for pupils injured in school athletics, held that boards of education are without authority to recognize and pay damages or doctor or hospital bills for pupils injured in interscholastic games as either legal or moral obligations.

* * *

FEES FOR AUTO INJURIES

One of the most troublesome problems confronting some physicians, especially those in general practice, and one responsible for many unpaid accounts on physicians' books, is that relating to the collection of fees for services rendered to persons injured in automobile accidents.

Obviously, persons injured in automobile mishaps do not come within the classification of indigents except in extremely rare and isolated instances. Probably 99 per cent of the individuals injured in this manner and requiring medical, surgical and hospital care are *not* entitled to medical and hospital services at public expense.

Frequently, a physician after rendering service to an automobile accident victim encounters considerable difficulty in collecting a fee for his services, either because all parties involved in the accident refuse to take the blame for the mishap or because the person injured may be a resident of another state. Furthermore, in some instances the physician is compelled to wait a long time for his money while litigation between the parties involved is being adjudicated.

Naturally, a physician cannot and should not

refuse to render emergency treatment to victims of automobile accidents. Nor should necessary medical and hospital care be denied such persons following the accident.

On the other hand, the physician should have a prompt, frank and business-like understanding with the patient concerning his financial obligation to the physician or with relatives or friends of the patient if the latter's condition is such that he can not or should not be consulted. The patient, or his relatives or friends, should be informed by the physician that regardless of who is responsible for the accident, or of subsequent litigation, the physician is entitled to a fee for services rendered and will hold the patient directly or person acting in his behalf, rather than an insurance company or other third party, legally responsible for the medical expenses incurred.

Federal Legislative Problems As Exemplified by Group of Bills to Revive Sheppard-Townerism

Proponents of Sheppard-Townerism are making a desperate drive at present to have Congress act favorably as soon as possible on at least one of the three measures they have had introduced.

Apparently, sponsors of the bills have a feeling that their chief hope for success lies in rushing through their pet proposals while Congress is busily engaged with urgent legislation and before it has had an opportunity to become fully aware of the features of the maternity and infancy triplets.

None of the three measures differs in principle from the old Sheppard-Towner Act which Congress repealed in 1929. There have been a few minor changes in the mechanics for carrying on the proposed elaborate and costly federalized system which was a failure from many angles during the seven and one-half years the Sheppard-Towner Act was in effect.

However, the old provision for annual appropriations to enable the federal government to make to subservient states certain basic grants of money is retained. Likewise, there is provision for the federal government to pay to each state a subsidy or dole equal to the amount of money that the state appropriates. The appropriations are planned to continue indefinitely.

With apparent disregard for facts and figures, advocates of the three measures are attempting to stampede Congress by emotionalism. Naturally, they have not informed members of Congress that this type of legislation is based on unsound principles; tends to promote bureaucracy; is a duplication of the duties and functions already placed by law on the United States Public Health Service; would be extravagant and unproductive of good results, if judged by past experience; is a usurption of the rights of the individual states; tends to destroy local initiative and responsibility, and adds to confusion to present methods of carrying on public health work in urban and rural communities.

Needless to say, proponents of this federalized-subsidy type of legislation have turned a deaf ear to pleas, even demands, for economy in government and retrenchment in governmental expenditures, especially at this time when federal, state and local governments are confronted with huge deficits and economic conditions generally are critical.

Apparently, they have found it expedient to ignore the public statement issued by President Hoover shortly after Congress convened in which the Chief Executive said:

"I wish to emphasize to the full extent of my ability the necessity, as a fundamental to recovery, the utmost economy of governmental expenditure of all kinds. Our people must realize that government can not continue to live in a depression upon the scale that was possible in times of great prosperity. * * * We should also at least be able to bring about the wholesale elimination of overlapping in the Federal Government bureaus and agencies which will also contribute materially to the program of economy. * * * The balancing of next year's expenditures and receipts and the limitation of borrowing implies the resolute opposition to any new or enlarged activities of the Government."

Obviously, they disagree with the conclusions reached by the National Advisory Committee on Education, which in its recent report to President Hoover after a long and thorough study of the field of education, made this significant observation:

"The matching of Federal money grants, with state or local funds, whether their use is for general or special educational purposes is a policy not to be favored in the field of education."

"But," argue the Sheppard-Townerites, "the amount provided for in our bills is small in comparison to the huge appropriations for many functions of government."

That's what all the special-interest groups say. That's the plea put up by every bureau and agency, many of which have nothing to justify their existence. Stack all these "meager" appropriations together in one pile, however, and the total is appalling. It furnishes one clew to the reason for government deficits and unbalanced budgets.

One of the most enthusiastic sponsors and supporters of legislation to set up another system of

federal maternal and infant hygiene is Senator Jones of Washington, who introduced one of the maternity measures (S 572) now pending before Congress.

In a recent radio address, Senator Jones, who is chairman of the Senate Committee on Appropriations, made the following comments regarding the present economic situation and pleaded for reduction in government expenditures:

"We must begin to deny ourselves individually as well as governmentally. We must show our patriotism by the practice of self-denial in these trying times of peace as we showed our courage in time of war. When our various lines of activity get down to what may be termed a sane, reasonable living base, our people will begin to come up to a higher common plane of living and reach heights of luxury greater than ever before. * * * As I said before our deficit is increasing from year to year. We must do something to stop this. Let me say to the people back home that we must curtail our expenses. The only way we can do it is to reduce appropriations. The people can help. Do not urge us to make this appropriation and that appropriation unless it is absolutely necessary. It may be of benefit to some particular locality, but unless absolutely essential, let it go for a while. Let us know that you are ready to deny yourselves and suffer inconvenience, to make sacrifices and agree to curtail expenditure of government money until our outgo and our income our balanced."

How Senator Jones reconciles his views expressed in his radio address with those he must have had when he introduced S. 572, which provides for an extravagant, economically unsound and unessential federal function, is a mystery.

The inconsistency shown by the Senator from Washington seems to be typical of a lot which goes on at the national legislature.

If Congress is really sincere in its desire to cut government expenditures, keep the government out of unnecessary functions and activities, and leave to the states some of the rights which are inherently theirs, its duty and interest should be clear and consistent.

Northern Tri-State Meeting in Toledo in April

A program of unusual interest has been arranged for the Fifty-Ninth Annual Meeting of the Northern Tri-State Medical Association, to be held in the Academy of Medicine Building, Toledo, April 12.

The meeting will open at 9 a. m. with a psychiatric clinic by Dr. O. O. Fordyce and Dr. N. W. Kaiser, of the Toledo State Hospital. Following an orthopedic clinic, conducted by Dr. Edward P. Gillette, Toledo, Dr. U. J. Wile, professor of dermatology, University of Michigan, will hold a dermatological clinic.

The afternoon session will open at 1 p. m. with an address by Dr. Wile on "The Fluid Status of Syphilis Therapy". This will be followed by a paper on "Papilledema" by Dr. Walter B. Parker, Detroit, and one by Dr. H. B. Lewis, professor of physiologic chemistry, University of Michigan, on "The Recent Study in Blood Chemistry".

An address by Dr. Stanley P. Reimann, Lankenau Hospital, Philadelphia, on "Sulphydryl—The Basis for Further Cell Division", and a paper by Dr. Max Ballin and Dr. P. F. Morse, Harper Hospital, Detroit, on "The Results of Parathyroidectomies", will conclude the afternoon session.

A banquet will be held in the evening at the Commodore Perry Hotel, at which the principal address will be made by Dr. Dean Lewis, professor of surgery, Johns Hopkins University, on "Lesions of Bone and Their Treatment".

Officers of the Association who arranged the program are: Dr. Carl D. Camp, Ann Arbor, Michigan, president; Dr. H. M. Senseny, Fort Wayne, Indiana, vice president; Dr. Edward B. Pedlow, Lima, secretary, and Dr. G. O. Larson, Laporte, Indiana, treasurer.

Federal Income Tax Procedure

Up to the time the March issue of *The Journal* went to press, Congress had not enacted a new federal revenue bill which, when and if enacted, probably will change the present statutes relative to federal income taxes.

As pointed out in the February issue of *The Journal*, pages 129-133, inclusive, federal income tax returns on income during 1931 should be made in accordance with and pursuant to the Revenue Act of 1928 and Regulations issued under authority thereof, the same as in 1930.

These returns must be in the hands of Collectors of Internal Revenue by March 15.

At the present time it seems highly probable that any action which Congress may take toward revision of the federal income tax law will have no effect on the procedure which must be followed in making out 1932 returns or on the tax which must be paid on 1931 income.

Authentic reports from Washington state that the majority and minority members of the House Committee on Ways and Means, before which the proposed new revenue act is pending, have decided to oppose any provision in the bill which would make income tax rates established in the new bill retroactive.

If this decision of the committee is adhered to, present income tax rates will apply to returns which must be submitted in March and which cover incomes for the year 1931. Any new rates which may be established in the new legislation would apply to income for 1932 which would be listed in returns to be made in 1933, if this policy is followed.

Whatever action Congress may take will have no effect in the procedure which should be followed now in making out 1932 income tax returns, which procedure was explained in detail in the February issue of *The Journal*.

Vital Statistics ⁂ Their Purpose and Importance ⁂ Legal and Professional Reasons for Cooperation by Physicians in Securing Such Data.

That vital statistics are necessary aids in the solution of important medical, health, social and economic problems every thoughtful, well-informed and progressive physician will readily admit.

Furthermore, to forward-looking members of the medical profession it is obvious that efforts must be made constantly to improve the methods of obtaining and assembling data on births and deaths so that statistics may be more promptly available and as complete as possible for those engaged in analyzing them and enumerating the significant factors they reveal.

However, occasionally, some Ohio physician, who, apparently, is not entirely familiar with the value of the information obtained from birth and death registration, voices the complaint that too much red tape has been woven about the task of reporting births and deaths, and that a hardship is being worked on attending physicians by requiring and requesting them to furnish in official reports considerable data, unscientific in nature, and in his opinion unnecessary.

As indicated by some physicians, it is difficult and sometimes impossible to obtain all the information requested in official blanks for the registration of births and deaths. Others are of the opinion that entirely too much clerical work is now required from the average physician by official state and national departments and bureaus, and that the work entailed by completing the birth and death certificates adds to the burden.

On the other hand, other physicians agree with government officials and statisticians that the information requested on the vital statistics blanks is of importance in studies of many important health, as well as social and economic, questions.

Likewise, the courts have held at different times, on similar questions, that a license to practice medicine is a conditional right and that physicians may be required, under police power or for the public good, to submit various kinds of reports, together with whatever additional information may be considered necessary and obtainable.

Section 218, General Code of Ohio, sets forth the following provisions for the registration of births in Ohio:

"Each birth that occurs in the state shall be immediately registered in the district in which it occurs, as hereinafter provided. Within ten days thereafter, the attending physician or midwife shall file with the local registrar of the district in which the birth occurred a certificate of birth, properly and completely filled out, giving all the particulars herein required. If there be no attending physician or midwife, the father or mother of the child, householder or owner of the premises, manager or superintendent of public or private institution in which the birth occurred, shall notify the local registrar within ten days thereafter of such birth having occurred. In such case, the local registrar shall secure the necessary information and signature to make a proper certificate of birth.

"*In case the attending physician* or midwife *certifies* as provided in Section 219 (quoted below), *that he or she does not possess and cannot obtain without an independent inquiry the information necessary to fill out items Nos. 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17 and 18* of the certificate required by Section 219, *the local registrar shall secure the necessary information to properly fill out such omitted items in such certificate from the father or mother of the child, householder or owner, etc.* * * *.

"Section 219. (What certificate of birth shall contain). "The certificate of birth shall contain the following items:

"(1) Place of birth; including state, county, township, village or city. If in a city, the ward, street and house number; if in a hospital or other institution, the name thereof instead of the street and house number.

"(2). Full name of the child. If the child dies without a name before the certificate is filed, enter the words died unnamed. If the living child has not been named at the date of filing certificate of birth, the space for full name of child, is to be left blank, to be filled out subsequently by a supplemental report, as hereinafter provided.

"(2-a). Full name of mother.

"(3). Sex of child.

"(4). Whether a twin, triplet, or other plural birth. A separate certificate shall be required for each child in a case of plural birth, giving number of child in order of birth.

"(5). Whether legitimate or illegitimate.

"(6). Full name of father, except in the case of illegitimate births.

"(7). Residence of father.

"(8). Color or race of father.

"(9). Birthplace of father.

"(10). Age of father at last birthday, in years.

"(11). Occupation of father.

"(12). Maiden name of mother, in full.

"(13). Residence of mother.

"(14). Color or race of mother.

"(15). Birthplace of mother.

"(16). Age of mother at last birthday, in years.

"(17). Occupation of mother.

"(18). Number of child of this mother, and number of children of this mother now living.

"(19). Certificate of attending physician or midwife as to attendance at birth; including statement of year, month, day, and hour of birth, and whether the child was alive or dead at birth. This certificate shall be signed by the attending physician or midwife, with date of signature and address.

"If the physician or midwife does not possess and cannot obtain without an independent inquiry, the information necessary to supply items 5, 6, 7, 8, 9, 10, 11, 12, 13, 15, 16, 17 and 18 of said certificate said physician or midwife shall so certify in said certificate * * * *."

Thus, it will be seen that the law is definite and specific as to the information that shall be requested on the certificate of birth; it does not provide that the items listed shall be the only ones contained in the birth certificate, implying that the state registrar of vital statistics may use his own discretion as to the addition of other questions on the printed forms.

Certificates of birth now distributed by the Division of Vital Statistics, State Department of Health, to registrars in the various health dis-

tricts of Ohio, contain only a few questions that are not listed in the General Code as mandatory items. Several questions relative to the trade, profession, or particular type of work done by the father and mother; the industry or business in which the work was done; the date when the father or mother was last engaged in this work, and total time spent in this work, are asked. In addition, there are several items having to do with the number of children previously born to the mother and several questions asked in explanation of stillbirth, should such be the case.

As stated in Section 218, General Code, in case the attending physician certifies that he or she does not possess and cannot obtain without an independent inquiry the information necessary to fill out a dozen or more of the items listed in the certificate, it becomes the duty of the local registrar to secure this information from the proper persons.

However, many physicians have learned from experience that in most instances it is possible to obtain the services of competent persons (relatives or neighbors) in filling out the non-scientific data requested on the registration blanks and that they may win the further good will of parents by rendering this additional service.

Following are some of the reasons why birth certificates are valuable and why birth registration is an important function, taken from a compilation of information by competent authorities in the field of vital statistics:

Ninety per cent of all Ohio births must be officially reported if Ohio is to remain in the U. S. birth registration area and continue to be recognized by the U. S. Bureau of Census.

Many questions concerning health longevity and population, as well as important social and economic problems, may be solved through studies based on analysis of birth statistics.

Data obtained through birth registration is a valuable aid in study of maternal mortality problems and questions concerning the insane, feebleminded and defective.

Every child is entitled to a proof of his age; his birth certificate is his proof.

A birth certificate is a child's record of his parenthood.

Nationality may be proved through a birth certificate.

Inheritance of property rights may often be protected by a certified copy of a birth record.

Rights to mothers' pensions may be proved by copies of registered births of dependent children.

Workmen's compensation benefits require proof that children are entitled to such rights; a birth certificate offers this proof.

In many communities a copy of a birth certificate must be presented upon entrance to school.

Before children of school age may enter industry they must obtain an employment certificate which requires their exact age; a birth certificate proves this age.

Graduation certificates and licenses to practice certain professions require a record of age; a birth certificate certifies the exact age.

Applications to take federal and state civil service examinations require furnishing proof of exact age.

Life insurance and annuities require correct records of age.

Voting age may be established by a birth certificate.

Proof of ctizenship, a requirement for jury duty, is established by a birth certificate.

Eligibility to public office, where citizenship is a factor, is established by a birth certificate.

Military service requires proof of age which may be obtained from authentic birth records.

Birth certificates furnish important evidence when the question of the right to marry is involved.

Proof of the date of birth is required for a passport to travel in foreign countries.

Occasionally, the criticism is made that certificates of death which must be filed with the Division of Vital Statistics, contain questions of minor consequence, entailing unnecessary work on the part of the attending physician.

The Ohio law, Section 209, General Code, enumerates the various items that must be included in a certificate of death.

The certificate now in use by the State Department of Health, Division of Vital Statistics, contains a number of items that are not listed in the law. However, the data obtained from the answers to these questions is deemed so valuable by statisticians and health authorities that it becomes a duty on the part of the attending physician to answer them if the information requested can be readily obtained.

For example, the medical section of the certificate, which is the only part of the report for which the physician is held responsible, furnishes valuable information relative to mortality of certain surgical operations; the mortality from various kinds of accidents, in industry, in the home or on the street; the reasons and causes for accidental deaths; the risks and dangers involved in various types of employment; the mortality of various occupational diseases; the mortality of childbirth, etc.

From the data obtained in these reports, preventive measures may be worked out by health authorities and other agencies for the promotion of health and control over disease, industrial safety, public safety, and safety in the home.

The physician, whether he realizes it or not, is the key-man in every system for the gathering of vital statistics. The data is valuable or worthless, depending on the willingness of the physician to cooperate; the degree of care he uses in seeing that the information furnished is accurate, and the amount of time he is willing to devote to a scientific undertaking that produces many valuable results.

In the opinion of most Ohio physicians, the time utilized by the doctor in obtaining the information requested and recording it on official birth and death certificates is well spent, since, if for no other reason, the data collected serves as an indispensable aid in the advancement of scientific medicine and the promotion of public health.

Expose of Two Well Known "Drugs" Extensively Exploited in Ohio

Ohio physicians who are not already familiar with the results of previous scientific investigations concerning the patent medicine, known as "The Converse Treatment", an alleged epilepsy cure, and recent investigations made of the highly-exploited "health water", known as "Electrovita", will be interested in recent exposes of both products by the Bureau of Investigation of the American Medical Association.

In the December 19, 1931, issue of *The Journal of the American Medical Association*, page 1910, the Bureau of Investigation presented the following report on "The Converse Treatment" which is self-explanatory:

"The Converse Company, which on its letterheads is described as 'The Converse Treatment Company', operates from 30 Smith Place Avenue, Columbus, Ohio. The head of the concern is said to be one Herbert E. Sanderson who, if reports are to be believed, has been in the 'patent medicine' business for about fifty years. Connected with Sanderson (according to the company's stationery) are Frank J. Dawson and Donald W. Dawson, with L. P. Jackson, M.D., as 'Medical Referee'.

"Dr. Louis P. Jackson of Columbus, who has practiced at Delphos and Van Wert, Ohio, was, according to the records, born in 1867 and holds a diploma from the Starling Medical College of Columbus for 1898. Dr. Jackson is not a member of his local medical society nor of the American Medical Association.

"The Converse Treatment has been discussed in *The Journal* at different times, but the large number of inquiries received by the Bureau of Investigation from both laymen and physicians makes it desirable to bring again to the attention of the profession and the public the facts regarding this mail-order exploitation of epileptics.

"In the days before the passage of the Food and Drugs Act, the Converse Treatment was known as the 'Converse Cure' and was described as 'The only positive cure known, adopted and recommended by the leading physicians of the country.' This statement, being one hundred per cent false, is no longer made by the company, although the implications in the 1931 advertising are almost as false and misleading. In the early days, the Converse nostrum was put out at Mt. Vernon, Ohio, by a Mrs. Converse, who was said to have 'discovered' the 'cure'. Although the company has for years claimed—and still claims—that its nostrum has been used by hospitals, sanitariums and physicians, no names or addresses are given to make a check-up on such claims possible.

"Since the concern has been under the control of Sanderson 'sucker lists' of epileptics have for many years been obtained by sending broadcast to officials in rural communities a printed circular offering a small dictionary, a fountain pen, a cook book or a song book, free to those who will send a given number of names of epilepsy victims.

"Of course, no information is given by the Converse concern regarding the composition of its product. In a booklet sent out at the present time, the public is told:

" 'The Converse Treatment is prepared of the purest and most carefully selected herbs and medicine in its component parts, and with scrupulous exactness. Its distinguishing characteristic is the employment of a certain herb. This herb is gathered at a distance for the Converse Company at a particular season of the year and prepared for use in its laboratory. The Converse Treatment avoids entirely the powerful drugs known as Opiates, so often given for this trouble and is free from Alcohol, Morphine, Opium, Cocaine, Chloral, Heroin, Eucaine, Chloroform, Cannabis Indica, Acetanilid, or any of their derivatives.'

"The implication plainly is that the Converse nostrum is essentially herbs. Listing drugs that a 'patent medicine' does not contain is an old trick in the business.

"In the same booklet from which the quotation given above is taken, it is stated that the Converse Treatment has never been advertised in newspapers or magazines, but that the demand has 'come entirely from results attained'. The facts are, of course, the demand has actually come from those victims of epilepsy who have received the plausible and misleading 'literature' of the Converse Company and whose names have been given the concern by those who are willing to furnish the contact at the price of a fountain pen or cook book.

"As long ago as 1912, the Converse Treatment was analyzed by the late Senator E. F. Ladd, when he was the aggressive Pure Food Commissioner of North Dakota. Professor Ladd's report showed that the essential drugs in the Converse Treatment were the bromides. In 1915, the A.M.A. Chemical Laboratory, at the request of the Bureau of Investigation, made a thorough analysis of the Converse Treatment and the findings confirmed the earlier analysis of the North Dakota chemists. The A.M.A. Chemical Laboratory reported that from its analysis, it was evident that those who took the Converse Treatment in the dosage recommended obtained bromides corresponding to 58 grains of potassium bromide daily.

"The Converse Teratment, quite obviously, has all the limitations and dangers of a bromide mixture."

* * * *

In the January 23, 1932, issue of *The Journal, A.M.A.*, pages 337-338, will be found an investigation of "Electrovita", which is manufactured at Norwalk, Ohio.

How "Electrovita" is being exploited and the misleading claims made for it are revealed in the Bureau's expose which also labels the product as nothing more than "weak lime water plus hokum".

The closing paragraphs of the article illustrate the hokum behind "Electrovita" and its absolute worthlessness as a remedy for the diseases for which it has been recommended by its exploiters.

"A gallon of Electrovita costs—or to be more correct, sells for—two dollars ($2.00), the Bureau of Investigation points out". For those who want a similar product minus the advertising hokum, we suggest that they take one cent's worth of lime and put it in a half-gallon of city water. After standing for some hours, in order that the water may become saturated with the lime, this half-gallon is poured off and diluted with another half-

gallon. At no greater expenditure than one cent, one may have the therapeutic equivalent of a gallon of Electrovita.

"For those who have nothing seriously the matter with them and are able, in these parlous financial times, to pay a fancy price for weak lime water, there may be no serious objection to the purchase of Electrovita. For those persons, however, who are suffering from cancer, tuberculosis and any other serious condition, and who may be led to believe by the sales talk of the Electrovita representatives that they can be cured by taking this nostrum, the situation is much more serious.

"Whether the men who are behind the Electrovita Company are self-deluded enthusiasts or unconscionable quacks makes little difference, so far as the end results of this exploitation may be concerned. In a properly-ordered society, where the health of the public should be the first consideration, a product of this sort could not be sold under the methods used in the exploiting of Electrovita."

Hints in Avoiding Explosion of Anesthetic Gases

Factors entering into the cause of the explosion of anesthetic gases in operating rooms have been studied with considerable thoroughness during the past few years due to the increased number of such unfortunate occurrences.

Records of such accidents have been compiled by various agencies and a number of interesting and informative studies made.

One of the most recent and most comprehensive surveys of this sort is that made by Dr. E. C. Cutler, professor of surgery at Western Reserve, University School of Medicine, and Dr. P. L. Hoover, D.Sc., professor of electrical engineering, Case School of Applied Sciences, for the purpose of designing a program that might be followed in the new Lakeside Hospital, Cleveland, so as to eliminate, insofar as possible, the danger of such explosions.

A presentation of the survey and study made by Dr. Cutler and Dr. Hoover, published in *The Modern Hospital*, concludes with a list of recommendations that should be followed in order to reduce or eliminate the fire and explosion hazard in operating rooms, as follows:

1. The prohibition of open flames and smoking in the operating rooms.

2. The maintenance of a relative humidity of 65 per cent, or higher, in all operating rooms.

3. The exclusion of woolen blankets or woolen fabrics from operating room use.

4. Anesthetic machines of the type that bubble the gases through water; or a strict adherence to the practice of inserting saturated sponges in the rubber bags each time the machine is used.

5. The absolute prohibition of the use of oils or greases for lubricating the anesthetic machines.

6. With the use of electrical apparatus that produces or is capable of producing an open spark, the prohibition of explosive anesthetic agents such as ether and ethylene.

7. The exercises of considerable precaution when thermal cauteries are used in the presence of inflammable anesthetics.

8. A thorough inspection at least once every six months by the electrician or other competent person, of all outlets, fixtures, lamps, cords and apparatus of the operating room, with particular care given to locating grounds and loose contacts.

9. Immediate attention to needed repairs or the removal of defective apparatus from the operating room.

Scientific Exhibit at Annual Meeting

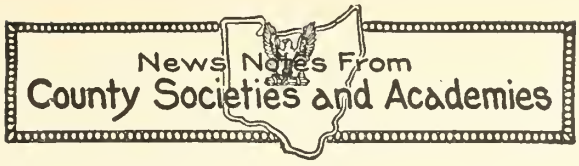
The Council of the State Association has approved the request of the Dayton Committee on Arrangements that a Scientific Exhibit be held in conjunction with the Eighty-Sixth Annual Meeting to be held at Dayton, May 3 and 4.

Scientific exhibits have occupied a prominent position at the annual meetings of the American Medical Association and at many of the annual meetings of state medical associations for a number of years, and it is the hope of the Dayton committee to make this feature at the forthcoming meeting of the Ohio State Medical Association one of the highspots of the gathering.

Dr. Walter M. Simpson, director of the diagnostic laboratories of the Miami Valley Hospital, Dayton, has been appointed chairman of the Dayton Committee on Scientific Exhibit. Dr. Simpson hopes that there will be one or two exhibits from each of Ohio's Class A medical schools, and that individuals not connected with medical schools also will present exhibits. Applications for the presentation of exhibits by persons not connected with medical schools will be given equal consideration with those from medical schools, Dr. Simpson has announced.

All applications for exhibits should be addressed to Dr. Simpson, who will furnish detailed information as to the space available and lighting accommodations. He also should be furnished with data as to the type of exhibit planned, the space and lighting arrangements required for it, etc.

Dr. William H. Wilder, 122 South Michigan Avenue, Chicago, secretary of the American Board for Ophthalmic Examinations, has announced that the board will hold examinations at New Orleans on Monday, May 9, 1932, at the time of the annual meeting of the American Medical Association in that city. Necessary applications for entrance to the examinations may be obtained from Dr. Wilder at the above address.



First District

ACADEMY OF MEDICINE OF CINCINNATI

(H. H. Shook, M.D., Secretary)

February 1—General Session. Union Central Building. Address, "The Care of the Dying", by Dr. Alfred Worchester, Harvard University.

February 8—Medical Section. Union Central Building. Program: Symposium on Pulmonary Tuberculosis. "Points in Diagnosis", Dr. C. E. Wooding; "Pneumothorax Therapy", Dr. D. W. Heusinkveld; "The Arrested Case", Dr. J. H. Skavlem. Discussion by Drs. Kennon Dunham, J. L. Tuechter and Vera Norton.

February 15—Surgical Section. Union Central Building. Program: "Extra Dural Hemorrhage and Chronic Sub-Dural Hematoma", Dr. B. N. Carter. Discussion opened by Dr. John A. Caldwell. "Treatment of Hare-Lip and Cleft Palates", Dr. Reed A. Shank. Discussion opened by Dr. C. A. Langdale.

February 22—General Session. Union Central Building. Address, "Some Highlights in the Medical History of Kentucky", Dr. A. T. McCormack, Louisville, Ky.

February 29—Specialty Section. Union Central Building. Program arranged by the Cincinnati Dermatological Society. Address: "The Therapeutic Problems of Syphilis", Dr. Paul A. O'Leary, director of the section of dermatology, Mayo Clinic, Rochester, Minn.

Butler County Medical Society held its regular monthly meeting, January 27, at the Fort Hamilton Hospital, Hamilton. The principal address on the scientific program was given by Dr. C. A. Coleman, Dayton, on "Recent Progress and Developments in Urology", which was of extreme interest to those attending.—H. O. Lund, Secretary.

Clinton County Medical Society at its regular meeting, held February 2, at the New Martin Hotel, Wilmington, heard a paper on "Psorasis", by Dr. F. A. Peelle and a report on the recent tri-state meeting of the American College of Surgeons at Pittsburgh, by Dr. W. L. Regan. A number of case reports by members also were submitted and discussed.—News Clipping.

Second District

Clark County Medical Society held its annual banquet the evening of January 13 at the home of Mrs. Elinor Kidder, Springfield, with 48 members and guests present. The speaker of the evening was the Hon. Stewart L. Tatum, Springfield attorney, who spoke on his recent trip through Spain. A vocal and instrumental musical program was presented by Misses Geneva and Martha Demarest. The society voted to send flowers to the City Hospital and to Dr. Howard Austin who is ill.

At a luncheon meeting of the society on January 27 at the Hotel Shawnee, Dr. R. W. Ramsey, Columbus, presented a paper on "Some Paradoxes of the Thyroid Gland".—E. C. Nehl, Secretary.

Greene County Medical Society held its January meeting, January 8, at the Court House, Xenia. A public health program was given, the principal address being made by Dr. R. H. Grube, county health commissioner, on the various aspects of scarlet fever. A luncheon at the Iron Lantern concluded the meeting.

The Society met on February 4 at Xenia with 16 members present. After the revised Constitution and By-Laws of the society had been given their first reading, Dr. H. M. Platter, Columbus, president-elect of the Ohio State Medical Association, addressed the group on "Our Obligations and Duties". Dr. Platter discussed various phases of medical economics and the activities of a county medical society. He said that the county society is the cornerstone of medical organization; that it must have the united support of the medical profession of the community, and is the proper forum for the discussion of medical problems. Dr. Platter urged that county societies devote serious study to questions of medical ethics, medical economics and periodic health examinations. He emphasized the great value of the family physician and urged active support by the county society of preventive medicine. Following a lively discussion, a luncheon was served.—R. R. McClellan, Secretary Pro-tem.

Miami County Medical Society held its February meeting, February 5, at the Stouder Memorial Hospital, Troy. An address, "Traumatic Surgery From the Standpoint of the General Practitioner", was made by Dr. H. R. Pearson, West Milton. Dr. Pearson illustrated his talk with a motion picture entitled, "Traumatic Surgery of the Extremities". Another film, "Spinal Anesthesia", also was shown.—News Clipping.

The annual dinner and joint meeting of the Miami and Shelby County Medical Societies was held January 8 at the Hotel Favorite, Piqua, with 50 in attendance. Dr. J. H. J. Upham, Columbus, dean of the College of Medicine, Ohio State University, was the principal speaker. Dr. Upham discussed the medical problems relative to

heart disease. He also reviewed medical problems in connection with World War veterans' legislation.—News Clipping.

Montgomery County Medical Society held its regular meeting, February 5, at the Fidelity Medical Building. Dr. Charles Goosmann, Cincinnati, was the principal speaker, talking on "Some Mistakes in Microscopic Diagnosis of Tumors". He also presented "Amateur Movies Through the Microscope".

On February 19, the society held a dinner meeting at the Dayton State Hospital.—Bulletin.

Preble County Medical Society held a dinner meeting January 21 at the Seven Mile Tavern. Dr. Roy C. Arn, Springfield, addressed the society on "Acute Brain Injuries".—News Clipping.

Third District

Allen County—Regular meeting of the Academy of Medicine of Lima and Allen County was held February 16 at the State Hospital for the Criminal Insane. A clinic was presented with Dr. W. H. Vorbau, superintendent of the hospital, in charge.

Dr. W. N. Taylor, Columbus, a member of the faculty at Ohio State University, College of Medicine, was the principal speaker at a meeting of the academy, held January 19, at the academy headquarters.—News Clipping.

Hancock County Medical Society held its regular monthly meeting at the Elks' Home at 5:30 p. m., Thursday, February 4, 1932. The first paper of the evening was given by Dr. R. N. Lee, Mt. Blanchard, Ohio, on "Pneumonia in Children." Following this very interesting paper a lengthy discussion was had by most of the members. Dr. J. H. Marshall then gave an instructive paper on "Endocervicitis" and followed this with a demonstration of the use of the high-tension electric knife.—H. O. Crosby, Secretary.

Hardin County Medical Society held its regular meeting February 3 at the Martin Restaurant, Kenton. Guests at the meeting were Dr. D. C. Houser, Urbana, president of the Ohio State Medical Association, and Dr. O. P. Klotz, Findlay, councilor of the Third District. They discussed problems confronting the medical profession and stressed the need for strong medical organization. —News Clipping.

Logan County Medical Society, at a largely attended meeting, January 8, listened to an address on "Civilization" by Dr. C. L. Bonifield, Cincinnati, and transacted routine business. Dr. A. J. McCracken acted as toastmaster at the dinner and meeting which was held at the Hotel Logan, and announced the selection of the following committees for the ensuing year: Program, Dr. M. L. Pratt and Dr. J. P. Harbert; censors, Dr. W. G. Stinchcomb, Dr. C. J. Bondley, Dr. Carrie Richeson and Dr. F. S. Wood; auditing, Dr. Robert Butler and Dr. F. S. Wood.—News Clipping.

Marion Academy of Medicine met in the ballroom of Hotel Harding, February 3rd.

Dr. Filmore Young, as program chairman, introduced the speakers and in his talk presented an enlightening outline of the careers of each.

Dr. E. L. Brady, president of the society, presided.

The subject of shock being the topic of the evening. Dr. H. L. Uhler, pioneer surgeon and physician in Marion County, who was presented as first speaker on the program, gave interesting phases of his wide experience in the medical field and supplemented his address with several personal experiences.

Definite signs and symptoms of shock together with the condition and reaction of the patient in cases of shock were illuminatingly discussed by Dr. Dodd in his paper. He also discussed his medical experience in France during the World War.

"Obstetrical Shock" was the subject of a paper by Dr. R. T. Morgan, in which he presented a number of the later views and opinions on the subject. Dr. E. H. Morgan discussed "Medical Shock". He confined his talk for the most part to shock experience in the administration of anesthetics and also stressed the importance of anticipating shock in these instances before they occur. Dr. Mouser gave an interesting resume of the topics in his discussion.—News Clipping.

Seneca County Medical Society was addressed by four Toledo physicians at its meeting on January 21 at the Shawhan Hotel. Those who spoke were: Dr. Norris Gillette, Dr. A. H. Schade, Dr. Charles Lukens and Dr. Joseph Gould. Following the addresses a general discussion was held.—News Clipping.

Van Wert County Medical Society met February 2 at the Van Wert County Hospital. The principal address was made by Dr. W. H. Vorbau, superintendent of the State Hospital for the Criminal Insane, Lima, on "Mental Health and the Relation of Psychic Symptoms to General Medicine". A round table discussion followed the address. About 20 physicians attended the meeting.—News Clipping.

Fourth District

ACADEMY OF MEDICINE OF TOLEDO AND LUCAS COUNTY

(A. P. Hancuff, M.D., Secretary)

February 5—General Session. Program: "Surgical Treatment of Cancer of the Colon", with lantern slide demonstration, Dr. Fred W. Rankin, chief of the section of surgery, Mayo Clinic, Rochester, Minn.; "Roentgenologic Diagnosis of Malignant Lesions of the Colon", with lantern

slide demonstration, Dr. B. R. Kirklin, chief of the section on roentgenology, Mayo Clinic.

February 12—Section of Pathology, Experimental Medicine and Bacteriology. Program: "Experimental Production of Endocarditis", Dr. Matthew Ginsberg; discussant, Dr. Bernhard Steinberg; "Tuberculosis of the Skin", case report with presentation of patient, Dr. Edward Binzer; "A Typical Case of Pernicious Anemia", case report, Dr. R. M. Burton.

February 19 — Medical Section. Program: "Pick's Disease—Polyserositis" with lantern slide demonstration, Dr. T. L. Ramsey; discussants, Dr. M. J. Larkin, and Dr. J. B Rucker, Jr.; "Pitfalls in the Diagnosis and Treatment of Acute Abdominal Conditions", Dr. E. J. McCormick.

February 26—Surgical Section. Program: "Clinical and Pathological Study of Some Unrecognized Common Lesions of the Appendix", Dr. Bernhard Steinberg.

At the Thirtieth Annual Banquet of the Academy, held January 8, at the Commodore Perry Hotel, Dr. E. B. Gillette, president-elect during 1931, was inducted into office, succeeding Dr. B. G. Chollett. Officers elected for the ensuing year were: President-elect, Dr. L. R. Effler; secretary, Dr. A. P. Hancuff; trustee, Dr. Chollett; member of council, Dr. T. L. Ramsey. A memorial program for members who had died during 1931 was held. At a meeting of the Board of Trustees, Dr. W. W. Beck was reappointed treasurer and at a meeting of the Council, the following appointments were made: Delegates to annual meeting of the State Association, Dr. E. J. McCormick and Dr. C. W. Waggoner; alternates, Dr. E. I. McKesson and Dr. Paul Hohly; censors, Dr. H. L. Green and Dr. T. M. Crinnion.

Putnam County Medical Society was addressed by Dr Lester Thomas, Lima, at its regular meeting on February 2 at the Hotel DuMont, Ottawa. His paper was on "Diseases of the Gall Bladder". —News Clipping.

Wood County Medical Society met in regular session January 21 at the Women's Building, Bowling Green. Dr. Fred Douglass, Toledo, was the principal speaker, reading a paper, illustrated by lantern slides, on "Procidentia".—R. N. Whitehead, Correspondent.

Fifth District

ACADEMY OF MEDICINE OF CLEVELAND

(Clarence H. Heyman, M.D., Secretary)

February 5—Clinical and Pathological Section. Demonstration at Mt. Sinai Hospital.

February 10—Pediatric Section. Demonstration and program at Babies' and Children's Hospital.

February 12—Experimental Medicine Section. Institute of Pathology. Program arranged by the Laboratory of Anatomy: "The Stabilizing Power of the Peroneus Group of Muscles", Dr. J. E. Hallisy; "Anatomical Mortality Statistics as a City Mirror", Dr. W. M. Cobb; "Velocities and Interruptions in Bodily Growth of Antropoid Infants", W. M. Krogman, Ph.D., "Roentgenographic Measurement of the Face in the Growing Child", with moving pictures, B. Holly Broadbent, D.D.S.; "Observations on Bone Growth as Influenced by Male Sex Hormone", Dr. T. T. Zuck.

February 17—Industrial Medicine and Orthopedic Section. Mt. Sinai Hospital. Program: "Congenital Dislocations of the Hip", Dr. C. H. Heyman; "Diagnosis and Treatment of Fractures of the Nose", Dr. M. T. Metzenbaum; "Treatment of Fractures of the Forearm", Dr. R. S. Reich; "Industrial Dermatoses", Dr. J. E. Fisher; "Reconstruction Problems", Dr. W. G. Stern. Patients were presented by the essayists.

February 19—General Session. Academy Auditorium. Program: "The Use and Abuse of Drugs in Asthma", Dr. Milton B. Cohen; "Recent Advances in the Problem of Vascular Disease", Dr. R. W. Scott.

February 26—Ophthalmological and Oto-laryngological Section. University Club. Program: "Removal of the Larynx—Report of Two Cases", Dr. S. B. Cowen; discussion opened by Dr. J. T. Collins; "Applied Embryology of the Human Eye", (stereopticon), Dr. John E. L. Keyes, Youngstown; "The Salivary Glands", (stereopticon), Dr. William V. Mullin.

Ashtabula County Medical Society held its regular monthly meeting at the Hotel Ashtabula, Ashtabula, Tuesday evening, January 12. A symposium on fractures was presented by Dr. John Dickenson and Dr. W. H. Duncan, both of Cleveland. Dr. Dickenson presented a paper on "Cranio-cerebral Injuries" and Dr. Duncan one on "Fractures of the Tibia and Fibula". An informal discussion followed the program. The Society held its annual dinner dance at the Hotel Ashtabula, Ashtabula, Tuesday evening, February 9. Dentists and druggists of the county were guests.—E. H. Merrell, Secretary.

Erie County Medical Society held its regular meeting, January 27, at the Hotel Rieger, Sandusky. Dr. Thomas L. Ramsey, Toledo, addressed the meeting.—News Clipping.

Lake County Medical Society held its annual meeting, January 26, at the Lake County Memorial Hospital. The following officers were elected: President, Dr. W. P. Ellis; vice president, Dr. G. O. Hedlund; secretary, Dr. B. T. Church. Following the business session, a motion picture on "Surgery of the Extremities" was exhibited.—News Clipping.

Lorain County Medical Society met in the parlors of St. Andrew's Episcopal Church, Elyria, on February 9 for its regular monthly meeting. The meeting was opened with a dinner. A program on "Pulmonary Tuberculosis—Diagnosis and Treatment" was presented by Dr. A. F. Massaro, Elyria Clinic.—Bulletin.

Medina County Medical Society held its regular January meeting on January 14 at the Evanon, Medina.—News Clipping.

SIXTH DISTRICT

The Union Medical Association at its meeting January 13 at the Elks' Club, Canton, elected Dr. Charles A. LaMont, Canton, president, to succeed Dr. J. G. Blower, Akron. Dr. H. S. Davidson, Akron, Councilor of the Sixth District, was re-elected vice president, and Dr. J. H. Seiler, Akron, was re-elected secretary.

Mahoning County Medical Society held its annual banquet January 19 at the Youngstown Club, Youngstown, with approximately 200 in attendance. Dr. A. E. Brant, newly-elected president of the society, presided as toastmaster and presented James Gheen, New York City, inspirational and humorous after-dinner speaker. While Mr. Gheen devoted most of his talk to jokes and wisecracking, he also worked into his remarks wholesome advice for physicians, urging them to take a leading part in civic activities and adopt a progressive program in their organized activities.—News Clipping.

On February 16, the society was addressed by Dr. Joseph Barach, Philadelphia, on "High Arterial Pressure; Etiology, Classification and Treatment".—Bulletin.

Portage County Medical Society met February 4 at the home of Dr. P. H. Zinkhan, Ravenna. Dr. J. R. Turner, Kenton, presented an interesting case report on "Tetany" and A. E. Hardgrode, general superintendent of the City Hospital, Akron, addressed the society on "Some Problems of Hospital Management". Mr. Hardgrode's talk was discussed by R. L. Hendee, manager of the Portage County Hospital, Ravenna.—Bulletin.

Stark County Medical Society at its regular monthly meeting February 9, at the Elks' Club, Canton, was addressed by two Columbus physicians. Dr. William D. Inglis spoke on "A Few Obstetrical Observations" and Dr. J. P. Farson on "Lobar Pneumonia in Children". Discussion on Dr. Inglis' paper was opened by Dr. Clair Fraunfelter, Canton, and on Dr. Farson's by Dr. F. G. King, Canton.—Bulletin.

At the annual meeting of the society on January 12, the following officers were elected: President, Dr. J. B. Dougherty, Canton; vice president, Dr. George Wenger, Massillon; secretary-treasurer, Dr. F. S. VanDyke, Canton; chairman of the board of censors, Dr. J. E. Purdy, Canton; delegates to state meeting, Dr. J. P. DeWitt and Dr. Charles LaMont.—News Clipping.

Summit County Medical Society at its regular monthly meeting, February 2, at the Akron City Club, was addressed by Dr. Louis Mark, Columbus. Dr. Mark discussed "Upper Respiratory Infections as Draining Into the Chest".—Bulletin.

Seventh District

Belmont County Medical Society held its monthly dinner meeting February 4 at the Kilkenny Inn, near St. Clairsville. The program was presented by Dr. Harold A. Miller, Dr. Maurice Hodgdon and Dr. Paul Dodds, all of Pittsburgh. —News Clipping.

Columbiana County Medical Society held installation ceremonies for its newly-elected officers at a meeting on January 12 at Columbiana. Those installed were: President, Dr. Guy E. Byers, Salem; vice president, Dr. J. W. Robinson, Lisbon; secretary-treasurer, Dr. T. T. Church, Salem; delegate to state meeting, Dr. J. M. King, Wellsville; alternate, Dr. J. M. George, Salem. The following committee appointments were announced: Medical defense, Dr. J. A. Fraser, East Liverpool; legislative, Dr. F. R. Crowgey and Dr. L. F. Derfus, Salem; censors, Dr. Seward Harris, Lisbon, Dr. P. O. Hartford, East Palestine, and Dr. M. D. McCutcheon, East Liverpool. —News Clipping.

Coshocton County Medical Society at its meeting January 28 at the nurses' home, Coshocton, was addressed by Attorneys T. H. Wheeler and Lloyd S. Leach, of Coshocton.—News Clipping.

Tuscarawas County Medical Society held its regular monthly meeting February 11 at the City Council rooms, Dover. Dr. R. R. Reynolds, Massillon, presented a paper on "Nasal Sinuses and Focal Infection". The subject was discussed by Dr. F. B. Larimore, New Philadelphia, and Dr. W. R. Keller, Dover.—Bulletin.

Eighth District

Fairfield County Medical Society held its January luncheon-business meeting on January 12 at the Florentine, Lancaster Twenty-four members attended and heard a paper by Dr. G. I. Nelson, a member of the medical faculty at Ohio State University, on "Anemia".—News Clipping.

Guernsey County Medical Society met Thursday, January 21 at 12 o'clock noon for their bimonthly luncheon. An excellent paper was read by Rev. T. D. Rees, pastor of the First Baptist Church, his subject being "Counting the Pulse". It was considered by those present one of the best papers on an eulogy of the doctor ever heard here, and was well received. A representative of the Petrolagar Laboratories was present and showed films on Colle's fracture, stab wound of

the liver, gunshot wound of the bladder, and peristalsis during digestion in the dog, cat and rabbit.

The bi-monthly luncheon of the Society, held on February 4, with an attendance of over 90 per cent. The meeting was devoted to a discussion of business conditions. A committee was appointed to arrange with the proper officials for the financial care of indigent sick, and another one to confer with the mayor concerning parking facilities. —O. Reed Jones, Correspondent.

Licking County Medical Society was addressed by Charles R. Hixson, manager of the Hixson Laboratories, Johnstown, at its dinner meeting, January 29, at the Warden Hotel, Newark. Mr. Hixson spoke on "The Laboratory and Preventive Medicine". There was a large attendance.—News Clipping.

Muskingum County Medical Society held a dinner meeting February 3 at the Zane Hotel, Zanesville, with 36 in attendance. The program was presented by Dr. Andre Crotti and Dr. R. A. Ramsey, both of Columbus. Dr. Crotti spoke on "Malignant Goiter" and Dr. Ramsey on "Thyroid Disease".—Beatrice T. Hagen, M.D., Secretary.

Perry County Medical Society at its meeting on January 18 at the Park Hotel, New Lexington, had as its guest speaker Dr. Albert Landrum, Columbus.—News Clipping.

Ninth District

Jackson County Medical Society presented a motion picture program at its meeting on February 2 at the Markay Theater, Jackson. The films dealt with surgical treatment for ulcer of the stomach and for repair of nerves and blood-vessels. About 100 physicians and their guests attended.—News Clipping.

Scioto County—Regular meeting of the Hempstead Academy of Medicine was held February 8 at the Recreational Hall, Nurses' Home. A paper on "Preoperative and Postoperative Care" was presented by Dr. W. F. Marting, Ironton. A buffet supper was served following the program which was arranged by Dr. H. F. Rapp and Dr. C. L. Ferguson.—Bulletin.

Tenth District

COLUMBUS ACADEMY OF MEDICINE

(John H. Mitchell, M.D., Secretary)

February 1—The Columbus Academy of Medicine met at the Y.W.C.A. for a dinner meeting which was arranged by the Eye, Ear, Nose and Throat Club of Columbus. Following the dinner, Dr. W. James Gardner, Cleveland, addressed the gathering on "Brain Tumor". He described in detail some of the newer methods now being used in detecting the exact location of the growth. Dr. B. H. Nichols, also of Cleveland, spoke briefly on work in brain tumors from the standpoint of the roentgenologist.

February 8—General session at the Carnegie Library. Program: "Agranulocytosis", an illustrated lecture by Dr. Charles A. Doan, professor of medical and surgical research, Ohio State University.

February 15—General session at the University Hospital. Program: Clinical demonstration by members of the hospital staff.

February 29—Section on General Practice. Program: "Periodic Health Examinations".

Crawford County Medical Society held its regular meeting February 1 at the Elks' Grill, Bucyrus. Dr. Clarence H. Heyman, Cleveland, addressed the society on "Manipulation of Joints". Following the address a buffet supper was served. —Bulletin.

Knox County Medical Society held a luncheon meeting January 28 at The Alcove, Mt. Vernon. Dr. Frank W. Harrah, Columbus, was the guest speaker. He presented a paper on "Preoperative and Postoperative Care of the Prostatic Patient", illustrating his talk with slides and charts.—News Clipping.

Pickaway County Medical Society held its annual meeting January 8 at the Berger Hospital, Circleville. Dr. A. F. Kahler, New Holland, was elected president; Dr. Howard Jones, Circleville, vice president, and Dr. Lloyd Jonnes, Circleville, secretary-treasurer. Dr. Howard Jones was elected a delegate to the state meeting and Dr. G. D. Sheets, Williamsport, legislative committeeman. Three members chosen to the council were Dr. D. V. Courtright, Circleville, Dr. Harry D. Jackson, Circleville, and Dr. G. D. Sheets.—News Clipping.

Ross County Academy of Medicine met at the Warner Hotel, Thursday, February 4, 1932, for their regular monthly meeting. Dr. Phillip J. Reel, guest speaker for the evening, gave a very interesting paper on "The Clinical Aspects of Uterine Fibroids." He used lantern slides illustrations. Dr. Loy Hoyt gave a brief talk, pointing out and explaining different items in making out the income tax report of this year.—W. C. Breth, Secretary.

Union County Medical Society had as its guests, members of the Delaware County Medical Society at a dinner meeting on February 9 at the Incor Hotel, Magnetic Springs. About 25 physicians from both counties attended. Following the dinner, Dr. E. J. Marsh, president of the Union County Medical Society, introduced Dr. H. M. Platter, Columbus, president-elect of the Ohio State Medical Association, who made the principal address of the evening. Dr. Platter discussed the principles and activities of medical organization.—Bulletin.

Deaths in Ohio

John H. Berry, M.D., Athens; University of Cincinnati, College of Medicine, 1910; aged 49; member of the Ohio State Medical Association, a Fellow of the American Medical Association, and a member of the American Psychiatric Association; died January 18 following an extended illness. Dr. Berry was a native of Highland County. Following his graduation from medical school, he became an assistant physician at the Longview State Hospital, Cincinnati, and later joined the staff of the State Hospital for the Criminal Insane, Lima. In 1919, Dr. Berry was appointed superintendent of the Athens State Hospital, a position he held at the time of his death. Dr. Berry was one of the leading authorities in Ohio in the field of mental hygiene. Besides his widow, Dr. Berry is survived by his mother, two brothers and one sister.

Richard E. Clevenger, M.D., Lima; retired; Miami Medical College, Cincinnati, 1886; aged 74; died January 16 of heart trouble. Dr. Clevenger practiced at Dola for 40 years, retiring in 1924 and moving to Lima. He leaves three daughters, three sisters and one brother.

Stephen E. Cone, M.D., Cincinnati; Miami Medical College, Cincinnati, 1896; aged 65; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died January 19 following a heart attack. Dr. Cone was educated in the Cincinnati public schools and had practiced in Cincinnati since his graduation from medical school. He was a former secretary of the Cincinnati Academy of Medicine; a member of the American Proctological Society and various Masonic orders. Surviving are his widow and one brother.

Delbert C. Fox, M.D., Kenton; Ohio State University, College of Medicine, 1909; aged 50; member of the Ohio State Medical Association and the American Medical Association; died January 18 from injuries received in an automobile accident. Dr. Fox was born in Broadway and following his graduation from medical school practiced for six years at Roundhead before moving to Kenton. During the World War, Dr. Fox held the rank of lieutenant colonel in the medical corps having been stationed at Camp Oglethorpe, Georgia. He was an active member of the American Legion, the Masonic Lodge and the Elks' Lodge. Surviving him are his widow, one son, one daughter, his mother, one sister and two brothers.

Edwin A. Heeker, M.D., New Madison, retired; Columbus Medical College, 1878; aged 82; former member of the Ohio State Medical Association and the American Medical Association; died January 28 following an extended illness. Dr. Hecker retired from active practice several years ago because of his health. Surviving are one daughter, one sister and one brother.

Joseph A. Kersehner, M.D., Lithopolis; Ohio Medical University, 1906; aged 60; former member of the Ohio State Medical Association and the American Medical Association; died February 3 following a two-years illness. Dr. Kerschner was a life-long resident of Fairfield County and had practiced for the past 25 years at Lithopolis. He is survived by one sister.

George W. King, M.D., South Point; University of Cincinnati, College of Medicine, 1910; aged 58; member of the Ohio State Medical Association and the American Medical Association; died January 6 after a brief illness. Dr. King, a native of Ashland, Kentucky, began the practice of medicine at Millersport, moving to South Point in 1913. Surviving are his widow, six children and one sister.

Joseph W. Lehr, M.D., Wooster; Cleveland College of Physicians and Surgeons, 1883; aged 73; died January 3 of chronic endocarditis. He is survived by five adopted children.

Edward J. Mahoney, M.D., Maple Heights, Cleveland; Hahnemann Medical College, 1928; aged 30; died January 22 at the Springfield Lake Tubercular Sanitarium. Dr. Mahoney was a member of the staffs at Bedford and Huron Road hospitals. Surviving him are his widow.

Charles C. Mandeville, M.D., Galion; Starling Medical College, Columbus, 1893; aged 66; former member of the Ohio State Medical Association and the American Medical Association; died January 17. Dr. Mandeville was born near Blooming Grove. He practiced medicine for two years in North Robinson before locating in Galion. Dr. Mandeville had always been interested in military affairs. For a time he was a lieutenant in Company L, Eighth Regiment, Ohio National Guard, serving in the Spanish-American War. During the World War he served in the medical corps, having been stationed at Camp Knox. Surviving are his widow and one daughter.

James M. Merryman, M.D., Columbus; University of Wooster, Medical Department, Cleveland, 1870; aged 88; died February 8. Dr. Merryman, a native of Tuscarawas County, was a veteran of the Civil War and a member of the 72nd General Assembly of Ohio. Dr. Merryman practiced for many years in Hilliards, moving to Co-

lumbus about 1900 and retiring from active practice six years later. He leaves his widow, two sons and one daughter.

Frank R. Morath, M.D., Columbus; University of Wooster, Medical Department, Cleveland, 1878; aged 75; former member of the Ohio State Medical Association and the American Medical Association; died January 16 at the Masonic Home, Springfield. Dr. Morath practiced for several years in Pickerington before moving to Columbus where he practiced for many years.

George C. Skinner, M.D., Hamilton; Miami Medical College, Cincinnati, 1879; aged 76; former member of the Ohio State Medical Association and the American Medical Association; died January 21 from a kidney ailment. Dr. Skinner had lived all his life in Hamilton and had practiced medicine there for 44 years, retiring about nine years ago. He was a former president of the Butler County Medical Society. Dr. Skinner, an amateur horticulturist, owned a large apple ranch in Oregon and annually made visits there to superintend the collection and disposal of the fruit. At the time of his death Dr. Skinner was the oldest of former interns of the Cincinnati General Hospital. He is survived by one daughter and three sons, one of whom is Dr. Daniel M. Skinner, Hamilton.

Arthur B. Smith, M.D., Lakewood; New York Homeopathic Medical College and Flower Hospital, 1897; aged 60; died January 20 of injuries received when his automobile was hit by a train in Cleveland. He is survived by a widow.

William J. Woodlin, M.D., Columbus; University of Michigan Medical School, 1895; aged 55; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died February 9. Dr. Woodlin had practiced medicine in Columbus for the past 30 years. He was the first colored physician to serve on the executive board of the Columbus Council of Social Agencies and was the founder of the Columbus Urban League. Dr. Woodlin for many years took an active part in social and health movements for the benefit of his race and was considered a leader among the colored population of Columbus.

John B. Woodworth, M.D., Cleveland; Cleveland University of Medicine and Surgery, 1893; aged 62; died January 1 after a four-months illness. Dr. Woodworth had practiced in Cleveland since his graduation from medical school. He was a member of the Sons of the American Revolution, the American Legion and the Masonic Lodge. During the World War he was a captain in the medical corps, stationed at Camp Custer. He leaves his widow and one daughter.

KNOWN IN OHIO

Thomas W. DeHass, M.D., Indianapolis; Medical College of Ohio, Cincinnati, 1883; aged 75; fellow of the American Medical Association; died at his home January 25. Dr. DeHass spent his early life in Highland County, moving to Indianapolis about 40 years ago. He leaves one son, one sister and three brothers.

Henry Illoway, M.D., New York City; Miami Medical College, 1869; aged 84; Fellow of the American Medical Association; died January 18. Dr. Illoway, who retired from active practice many years ago, had practiced in Cincinnati for about 25 years before moving to New York City. He was at one time on the staff at the Cincinnati Jewish Hospital and professor of diseases of children at the Cincinnati College of Medicine and Surgery. He devoted much of his later life to writing, one of his chief works being "The American Text Book of the Diseases of Children". Dr. Illoway was a native of Czecho-Slovakia.

John C. McMichael, M.D., Windermere, Florida; Cleveland College of Medicine and Surgery, 1895; aged 67; former member of the Ohio State Medical Association and the American Medical Association; died January 20 of heart disease. Dr. McMichael retired in 1921. He is survived by his widow, one daughter and three brothers.

Calmar C. Owen, M.D., Chicago Heights, Illinois; Chicago Homeopathic Medical College, 1890; aged 67; died January 3. Dr. Owen formerly resided at Claridon, Marion County, and St. James, Illinois. Burial was made at Claridon. He leaves two daughters, one son and one sister.

Charles W. Salisbury, M.D., Los Angeles; Starling Medical College, 1882; aged 76; former member of the Ohio State Medical Association; died January 21. Dr. Salisbury practiced medicine in Dayton for 35 years before moving to Los Angeles about 10 years ago. He was a native of Brown County where his father practiced medicine for many years. Surviving are his widow, one daughter, one son and two sisters.

Daniel Harris Squires, M.D., Sarasota, Florida; Columbus Medical College, 1880; aged 81; former member of the Ohio State Medical Association; died January 4 of heart disease. Dr. Squires formerly lived in Ashville, Pickaway County. He was a member of the Pickaway County Medical Society until he retired from active medical practice about 35 years ago to enter the drug business under the name of D. H. Squires and Son. He had lived in Sarasota for the past eight years. He is survived by his widow, one son, one daughter and one brother.

Arthur Charles White, M.D., Chickasha, Oklahoma; Toledo Medical College, 1897; aged 59; fellow of the American Medical Association; died January 18. For five years after his graduation from medical school, Dr. White practiced in Toledo and then moved to Chickasha. He leaves three daughters, two of whom reside in Toledo, and a brother of Toledo. Burial was made in Toledo.

NEWS NOTES of OHIO

Lima—Approximately 25 physicians from Lima and surrounding communities participated in the eighth annual clinical tour staged by the Physicians Travel Club of Lima the middle of February. This year's tour took the physicians to Boston and New York City.

Cleveland—At the annual meeting of the Cleveland Medical Library Association the following officers were elected: President, Dr. Geo. Edw. Follansbee; chairman of the board, Dr. C. L. Cummer; director of finance, Dr. Charles W. Stone; director of library, Dr. Carl H. Lenhart; director of maintenance, Dr. Alfred A. Jenkins; director of program and extension, Dr. Howard Dittrick; director of membership, Dr. Theodore Miller; secretary, Dr. L. A. Pomeroy; treasurer, Dr. Frank S. Gibson; curator of museum of historical and cultural medicine, Dr. Dittrick; curator of incunabula, Dr. E. H. Cushing; curator of dental library, Dr. J. F. Stephan; trustees, Drs. R. H. Birge, W. E. Bruner, J. P. Sawyer, Follansbee and Cushing.

Toledo—Drs. Karl D. Figley, Stanley Giffen and L. I. Clark have been named to represent the Toledo Academy of Medicine on the board of advisers assisting in the distribution of food to the city's indigent.

Cleveland—Dr. D. G. Allen has sailed for Vienna where he will take post-graduate work in ophthalmology.

Cincinnati—The following committee has been appointed to make plans for the annual meeting of the Medical Alumni Association of the University of Cincinnati next June: Drs. William Abbott, A. C. Bachmeyer, Harry Box, B. L. Bryant, Frank B. Cross, Stanley Dorst, William M. Doughty, Louis Feid, Jr., Henry Freiberg, Martin H. Fischer, Ralph Good, Fred Heinhold, A. L. Knight, J. C. Oliver, Louis Ransohoff, Helena Ratterman, Mont Reid, Parke G. Smith, J. L. Tuechter, and Carl A. Wilzbach.

Cincinnati—Dr. Edward King addressed the middle section meeting of the American Laryngological, Rhinological and Otological Society, held at the La Salle Hotel, Chicago.

New Lexington—Dr. J. G. McDougal has been appointed physician at the county home and county jail.

Shelby—The local Rotary Club was addressed by Dr. J. F. McHugh on "The Ancient Practice and Development of Medicine and Surgery".

Columbus—Dr. E. R. Hayhurst has been re-elected president of the Columbus Council of Social Agencies.

Cincinnati—Dr. Clarence A. Mills, director of the Research Laboratory, University of Cincinnati, College of Medicine, addressed the Cincinnati Dental Society on recent advances in scientific medicine.

Crooksville—Dr. J. Obenour and Dr. J. S. Camp, formerly of Roseville, have opened office here.

Piqua—Dr. Hugh Wellmeier, formerly of Dayton, has moved to Piqua and has become an associate of Dr. C. E. Hetherington.

Important Notice to Delinquent Members

In compliance with federal postal regulations, the names of all unpaid members of the State Association must be removed from *The Journal* mailing list after this issue.

If you are among those on the "delinquent" membership list of the State Association, your membership dues for 1932 should be transmitted to the Secretary-Treasurer of your medical society or academy of medicine *immediately.*

Prompt payment of dues will insure the continuance of *The Journal*, as well as other organization benefits. All physicians should be anxious to receive the April issue which will contain the complete program and announcements of the Eighty-Sixth Annual Meeting of the State Association to be held at Dayton, May 3 and 4.

Membership dues for 1932 were due on or before January 1. As a courtesy to those who through neglect or oversight have thus far failed to pay their 1932 dues, *The Journal* has been mailed to them for the first three months of this calendar year.

Canton—Dr. H. M. Schuffell described the progress of modern surgery at a recent meeting of the Temple Round Table Club at the Hotel Obesto.

New Philadelphia—The local Masonic Lodge was addressed recently by Dr. A. H. Syler, Sugar Creek.

Painesville—Dr. E. L. Haffner, Fairport, has been appointed county physician by the Lake County commissioners.

Cambridge—Dr. D. L. Cowden of this city was a recent speaker before the Quaker City Chamber

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of Commerce, talking on "Public Health and Its Administration".

Clyde—The Clyde Farm Bureau was addressed by Dr. C. R. Pontius, Fremont.

Doylestown—Dr. E. C. Stepfield was the principal speaker at a recent meeting of the Doylestown Rotary Club.

Kenton—Dr. Kent C. Melhorn, formerly of Kenton, now with the Department of Medicine, U. S. Navy, has been appointed medical envoy with the United States delegation at the disarmament conference at Geneva.

Bryan—Dr. B. C. Bly, formerly of Montpelier, has moved into the offices of the late Dr. M. V. Replogle.

Cleveland—Dr. Claude S. Beck, assistant professor of surgery, Western Reserve University, School of Medicine, addressed the Johns Hopkins Medical Society, February 8, on "The Surgical Treatment of Pick's Disease and Pneumocardiac Temponade in Relation to Surgery of the Heart".

Clyde—Dr. George W. Smith, formerly of Cleveland, has opened offices here.

Troy—Dr. Burton E. Hyde has been re-employed by the county commissioners as county physician for the year 1932.

Columbus—Dr. L. L. Bigelow has sailed on the Aquitania for a cruise in the Mediterranean.

Wooster—The scope of modern medicine and the functions of organized medicine were reviewed by Dr. H. G. Wishart at a recent meeting of the Wooster Kiwanis Club.

Hamilton—Diseases which hold the higher brackets in mortality tables were discussed by Dr. Walter Simpson, Dayton, in a recent address before the local Rotary Club.

Wooster—The Wooster Lions Club was addressed by Dr. Williard S. Stoner, Cleveland, on "The Doctor's Responsibility in the Trend of Modern Medicine".

Cincinnati—Dr. Roger S. Morris has been appointed medical director of the new city retirement system.

Toledo—Dr. W. E. Obetz, of the Division of Safety and Hygiene, State Department of Industrial Relations, addressed a meeting at the Industrial Steel Castings Company of foundrymen of the Toledo area. He spoke on the value of first aid.

Ironton—Dr. Ralph Massie addressed a recent meeting of the Greenup (Ky.) County Medical Society.

Ashland—Dr. George P. Riebel has been appointed physician at the Ashland County Home.

Hamilton—Hamilton's new school physician is Dr. Mary P. Manning.

Vermillion—The local Rotary Club was addressed recently by Dr. Lyle Hill, Sandusky.

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Clinical and Laboratory Diagnosis Meeting in Columbus

Eleventh annual meeting of the Ohio Society of Clinical and Laboratory Diagnosis was held in Hamilton Hall, Ohio State University, Columbus. January 23.

The meeting was opened with a clinico-pathological conference on "Subacute Bacterial Endcarditis" at the University Hospital. The conference was well attended and pronounced one of the most valuable features of the entire meeting.

At the scientific session in the afternoon, the following papers were presented:

"Lymphoblastoma of the Tonsils, Case Report", Dr. R. S. Fidler, Springfield.

"Skin Testing for Protein Sensitization", Dr. Jonathan Forman, Columbus.

"Multiple Serositis, Pick's Disease", Dr. Thomas L. Ramsey, Toledo.

"Diabetic Neuritis with Paralysis", Dr. W. M. Sheppe, Wheeling, West Virginia.

"Significance of Agglutionation Tests in Tularemia and Undulant Fever", Dr. Walter Simpson, Dayton.

"Nephritis and Nephrosis", Dr. F. C. Hodges, Huntington, West Virginia.

"Appendix in Early Measles", Dr. Mortimer Herzberg, Cincinnati.

The meeting was concluded with a banquet at the Faculty Club at which Dr. Charles A. Doan, professor of medical and surgical research, Ohio State University, College of Medicine, was the principal speaker.

At a business session, the following officers were elected: President, Dr. Mortimer Herzberg, Cincinnati; vice president, Dr. R. G. Schnee, Cleveland; secretary-treasurer, Dr. A. H. Schade, Toledo.

It was decided to hold the next scientific session of the society in Columbus in January, 1933, and to hold a business session this coming May in Dayton at the time of the Eighty-Sixth Annual Meeting of the Ohio State Medical Association at a time which would not conflict with any of the sessions of the State Association meeting.

A Non-Surgical Consideration of Prostatic Enlargement. Edwin W. Hirch, M.D., Associate in Urology, College of Medicine, University of Illinois; urologist, Englewood Hospital, Chicago. Bruce Publishing Company, Minneapolis and St. Paul.

PUBLIC HEALTH NOTES

—Several district health conferences have been held in various parts of the state since the first of the year. The following abstracts taken from reports on these meetings published in the *Ohio Health News* give some idea as to the purpose of the conferences and the enthusiasm and interest displayed:

Lima entertained the Northwestern District Ohio Public Health Federation in an all-day session, January 28, when nearly half a hundred health commissioners, public health nurses, sanitary inspectors and guests met in consideration of the mutual problems pressing for solution in that territory. No action was taken, but there was substantial consensus of opinion that official public health workers and others who are specifically interested in public health problems should be closely united in a strong and well financed organization, capable of correlating work and policies of the non-official health agencies.

Health commissioners and nurses held sectional meetings at the court house in the morning. The most significant action taken by the nurses was a pledge that nurses of the district would follow lead of the health commissioners in any action deemed necessary to strengthen and otherwise improve and expand the existing state organization.

In the commissioners' section, a resolution was adopted asking the State Department of Health to obtain a ruling of uniform application, from the inspection division of the auditor's department, with respect to making emergency expenditures for the relief of indigents. Methods approved by specific inspectors in certain districts have been disapproved by others in other districts, and there was unanimous agreement that procedure in these cases should be uniform.

Following a luncheon at the Hotel Norvall, there was a joint session, at which the scheduled speaker was William Kennedy, executive secretary of the Sandusky Chamber of Commerce, introduced by Dr. F. M. Houghtaling, health commissioner of that city and Erie County, president of the State organization. Mr. Kennedy's talk included a series of rousing arguments in favor of a close, strong organization, with ample financial support.

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Brief talks also were made by the Director of Health, Dr. H. G. Southard; Dr. E. R. Shaffer, chief, Division of Local Health Organization; Miss Martha Laffey, speaking for the nurses; Dr. John E. Monger, former director, and Capt. Paul Mason, director of publicity. Miss Inez Gilliland and R. F. Mead were also among those representing the central department.

Among others present were: Dr. Roy C. Hunter, Auglaize County health district; Dr. Orland H. Good, Van Wert city health district; Dr. W. B. Finefrock, Ottawa County; Dr. Guy T. Wasson, Crawford County; L. W. Gibson, Fostoria; Dr. Charles R. Keyser, Van Wert County; Dr. J. D. Westrick, Defiance; Dr. F. F. DeVore, Lucas County; Dr. Frank Light, Putnam County; Dr. J. H. Holcomb, Hardin County; Dr. B. S. Stephenson, Sidney and Shelby County; J. H. Miller, sanitary inspector, Sandusky; Robert Coleman, U. S. Standard Products Company, Chicago; Mrs. John E. Monger.

Dr. Hunter was elected president and Dr. Stephenson secretary-treasurer by the health commissioners. Miss Laffey was elected chairman by the nurses' section, which carries with it the vice presidency of the district organization. Nineteen nurses were present from the various health districts.

* * *

One of the largest district meetings of health workers since the formation of their official State and sectional organizations was held at Steubenville, Jan. 14, when Northeastern District health commissioners, nurses, sanitary officers and laboratory workers met as guests of Julius A. Pizzoferrato, lately re-elected city health commissioner. The session included sectional meetings during the morning by the health commissioners, the nurses and the sanitary officers and laboratory workers, with a joint luncheon meeting and afternoon session.

Dr. H. G. Southard, director of health, and former director, Dr. J. E. Monger of Columbus, were among the speakers. James E. Bauman, assistant director of health, presented a paper on "Legal Status of Boards of Health and Their Employes", and Robert Horeiman, Alliance, of the Association of Master Foundrymen, had a talk on "Organization".

Dr. F. M. Sayre, health commissioner of Canton, presided over the health commissioners' section, which was devoted to a discussion of district problems. In the nurses' section, Miss Mary Missere, R. N., of the Canton health department, had a paper on the nursing phase of tuberculosis control, and Miss Ann G. Hill, R. N., of the Steubenville department, spoke on health education. In the inspectors' section there were papers by Charles McDonald, chief food and dairy inspector of Akron, and J. W. White, sanitary inspector of Canton.

* * *

Close to half a hundred health commissioners and more than that many public health nurses attended the meeting of the Central Conference District held at the Neil House, Columbus, Thursday, January 21. There was much discussion of the recently promulgated barber shop regulations, with some time given to consideration of local questions. The Conference elected Dr. R. E. Bowers, of Chillicothe and Ross County, president, and re-elected Dr. James F. Wilson, Washington C. H. and Fayette County, secretary.

Dr. John E. Monger, former director of health, entertained the health commissioners and a number of other guests at luncheon.

The next meeting will be held, some time in April, in Portsmouth.

—Attorney General Gilbert Bettman has rendered an opinion to the State Department of Health in which he held that Section 1261-36, General Code, is mandatory and that under it a municipality must provide suitable quarters for the city board of health.

—The fourth annual health essay contest for high school juniors and seniors, sponsored by the Gorgas Memorial Institute, Washington, D. C., will close March 15. This year's subject is "Mosquitoes: Their Danger as a Menace to Health, and The Importance of Their Control".

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HOSPITAL NOTES

—The city health department has the power to inspect sanitariums and hospitals to determine if they are complying with state laws and regulations, Assistant City Law Director Schweid, Cleveland, has informed City Health Commissioner Knapp.

—Dr. T. T. Rosendale has been elected chief of staff of the Fostoria City Hospital, and Drs. N. C. Hatfield and C. A. Henry, assistant chiefs.

—A reorganization of the staff at Mt. Carmel Hospital, Columbus, followed the retirement of Dr. Charles S. Hamilton as chief of staff to become a member of the board of trustees. The medical affairs of the hospital will be directed by an advisory board composed of the following: Drs. Robert B. Drury, chief of surgery; Dr. J. J. Coons, chief of medicine; Dr. C. E. Turner, chief of obstetrics; Dr. Hugh G. Beatty, chief of eye, ear, nose and throat, and Dr. E. J. Emerick, chief of neurology.

—Dr. Curtiss Ginn has been elected chief of staff at St. Elizabeth's Hospital, Dayton, succeeding Dr. G. A. Hochwalt, who has been named honorary chief of staff. Dr. J. K. Hoerner will be secretary of the staff. The following staff appointments have been made:

Consulting Surgeons—Dr. F. C. Gray and Dr. C. P. Grover.

Senior Attending Surgeons—Dr. A. W. Carley, Dr. Curtiss Ginn and Dr. R. L. Johnston.

Junior Attending Surgeons—Dr. C. Fischer, Dr. C. J. Derby and Dr. O. B. Burke.

Senior Attending Physicians—Dr. C. D. Smith, Dr. S. E. Hendren, Dr. H. W. Reck, Dr. C. R. Weis, Dr. A. F. Kuhl and Dr. H. D. Cassell.

Associate Physician—Dr. J. B. Lloyd.

Junior Attending Physicians—Dr. T. E. Newell, Dr. L. J. Lohr and Dr. R. C. McNelly.

Eye, Ear, Nose and Throat—Dr. John W. Millette, consultant; Dr. R. S. Binkley and Dr. F. J. Driscoll, seniors, and Dr. H. W. Angell, junior.

Attending Pediatricians—Dr. S. H. Ashmun and Dr. Wallace Taggart, seniors; Dr. S. J. Winter, associate, and Dr. W. E. Dapp and Dr. H. L. Strohmeyer, juniors.

Urologists—Dr. C. D. Padan, senior, and Dr. Dwight Fritz, associate.

Obstetricians—Dr. W. G. Clagett, and Dr. J. K. Hoerner, seniors; Dr. N. C. Hochwalt, associate.

Dr. J. A. Judy, senior orthopedic surgeon; Dr. W. H. Delscamp, roentgenologist; Dr. F. C. Payne, pathologist; Dr. C. R. Weis, cardiologist; Dr. C. C. McLean, Dr. J. K. Larkin and Dr. John Heath, anesthetists; Dr. O. B. Kneisley and Dr. H. R. Gogstetter, dental surgeons; Dr. M. R. Haley, Dr. Joseph S. Koehler, Dr. C. J. Ryan, Dr. E. F. Pfanner and Dr. W. S. Powell, out-patient department.

—President of the Christ Hospital, Cincinnati, medical staff for the ensuing year will be Dr. Robert Cofield. Other officers are: Vice president, Dr. David Tucker, and secretary, Dr. Charles Kiely. The following interns for 1932-33 have been appointed: George E. Ellerbrook, L. Nill Shroder, Gaston D. Hannah, Raymond L. Hilsinger, Stanley W. Whitehouse, Glover T. Keen, Charles Howard, and Albert G. Hattendorf.

—Dr. R. H. Spence has been elected president

140

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of the staff at the Lake County Memorial Hospital, Painesville. Dr. B. S. Park was chosen vice president and Dr. G. O. Hedlund, secretary. The executive committee is composed of these officers and Drs. F. J. Dineen, B. T. Church and V. N. Marsh.

—Dr. Brack Bowman, Glendale, has been appointed pathologist at the Fort Hamilton Hospital, Hamilton

—Miss Dessa Shaw, for more than 20 years superintendent of the Ball Memorial Hospital, Piqua, has resigned, and has been succeeded by Miss Cora B. Anderson, assistant superintendent for some time.

—Dr. Morgan C. Davies has been elected president of the board of directors of Radium Hospital, Columbus.

—Memorial Hospital (Fremont) staff has elected the following officers: President, Dr. D. W. Philo; vice president, Dr. S. McKenney; secretary-treasurer, Dr. F. M. Teeple.

—The following have been appointed interns at Mt. Sinai Hospital, Cleveland: Dr. Joseph I. Goodman, Dr. R. R. Maier, Dr. Harold Rand, Dr. R. Strauss, Western Reserve; Dr. M. Dworkin, Rush Medical college; Dr. Jerome Wertheimer, Dr. Samuel Lobe, Ohio State University; Dr. Ben Pilloff, St. Louis University; Dr. Irwin R. Schoen, Cincinnati University; Dr. N. W. Selznick, Toronto University. Resident physicians—Dr. John C. Drake, Dr. H. Reitman, Dr. Joseph Gross, Western Reserve; Dr. Herman Sampliner, St. Louis University.

—Dr. Valloyd Adair has been elected president of the medical staff at St. Joseph's Hospital, Lorain. Other officers chosen are: Vice president, Dr. H. S. Ross; secretary-treasurer, Dr. Waite Adair.

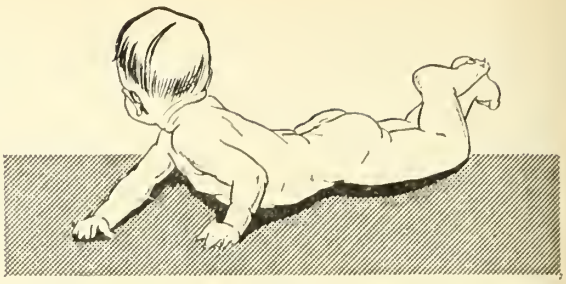
—The following officers, departmental directors and staff appointments at Bethesda Hospital, Cincinnati, have been announced by Dr. J. A. Diekmann, superintendent:

Dr. Frank D. Phinney, president; Dr. S. S. Amidson, vice president, and Dr. C. E. Eha, secretary-treasurer. Directors of the various departments: Surgery, Dr. C. T. Souther; medical, Dr. C. E. Geiser; obstetrics, Dr. Thad. Gillespie; gynecology, Dr. H. H. Wiggers; eye, ear, nose and throat, Dr. C. C. Jones; children's hospital, Dr. C. W. Beaman; orthopedics, Dr. Walter R. Griess; urology, Dr. E. O. Swartz; dental surgery, Dr. C. Burmeister; neurology, Dr. A. W. Foertmeyer; dermatology, Dr. Karl G. Zwick; radiography, Dr. E. R. Bader; pathology, Dr. O. Berghausen, and anesthesia, Dr. F. H. Harris.

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Plans are being made by the Cincinnati Academy of Medicine for an art exhibit, consisting of painting, sculptoring, carving, etching and photography done by members of the Academy. If a sufficient number of members respond to a questionnaire on the plan it is hoped to have the exhibit on display at the Cincinnati Art Museum.

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APRIL 1, 1932

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Number - - - 4

86th Annual Meeting, Ohio State Medical Association, Dayton, Ohio, May 3 and 4 ≈≈≈ Program, Special Features, Added Attractions, Reduced Railway Fares, and Other Announcements, Pages 281 to 292, Inclusive, of This Issue.

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Wood	O. S. Canright, Haskins	F. V. Boyle, Bowling Green	3d Thursday, monthly.
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Ashtabula	P. J. Collander, Ashtabula	E. H. Merrell, Geneva	2nd Tuesday, monthly.
Cuyahoga	H. G. Sloan, Cleveland	Clarence H. Heyman, Cleveland	3d Fri. March, May, Sept., Nov., Dec.
Erie	H. W. Lehrer, Sandusky	G. A. Stimson, Sandusky	Last Wednesday, monthly, except July, Aug., Sept.
Geauga	W. C. Cory, Chardon	Isa Teed-Cramton, Burton	Last Wednesday, Apr. to Dec.
Huron	John A. Sipher, Norwalk	B. C. Pilkey, Norwalk	3d Tuesday, Feb., May, August, Nov.
Lake	W. P. Ellis, Painesville	B. T. Church, Painesville	4th Tuesday, monthly.
Lorain	David Thomas, Lorain	W. E. Hart, Elyria	2d Tuesday, monthly.
Medina	Harry Street, Litchfield	J. K. Durling, Wadsworth	1st Thursday.
Trumbull	Frank La Camera, Warren	R. H. McCaughtry, Warren	3d Thursday, monthly, except June, July, August.

Societies	President	Secretary	
Sixth District	C. A. La Mont, Canton	J. H. Seiler, Akron	2d Wed., Jan., April & Oct.
Ashland	W. F. Emery, Ashland	Paul E. Kellogg, Ashland	2nd Friday, Sept. to May.
Holmes	L. E. Anderson, Mt. Hope	C. T. Bahler, Walnut Creek	1st Tuesday, quarterly, Jan., April, July, October.
Mahoning	A. E. Brant, Youngstown	W. M. Skipp, Youngstown	3d Tuesday, monthly.
Portage	Paul H. Zinkhan, Ravenna	E. J. Widdecombe, Kent	1st Thursday, monthly.
Richland	W. H. Buker, Bellville	P. A. Stoodt, Mansfield	3d Thursday, monthly.
Stark	J. B. Dougherty, Canton	F. S. VanDyke, Canton	2d Tuesday, monthly.
Summit	E. R. Stumpf, Barberton	A. S. McCormick, Akron	1st Tuesday, monthly.
Wayne	E. H. McKinney, Doylestown	R. C. Paul, Wooster	2d Tuesday, monthly.
Seventh District			
Belmont	W. M. Garrison, St. Clairsville	C. W. Kirkland, Bellaire	2d Wednesday, monthly at 1:45 p.m.
Carroll	(With Stark Co. Society)		
Columbiana	G. E. Byers, Salem	T. T. Church, Salem	2d Tuesday, monthly.
Coshocton	R. E. Hopkins, Coshocton	J. D. Lower, Coshocton	4th Thursday, April, June, Sept., December.
Harrison	A. C. Grove, Jewett	W. C. Wallace, Hopedale	3d Wednesday, monthly.
Jefferson	Victor Biddle, Steubenville	John Y. Bevan, Steubenville	Last Thursday, monthly.
Monroe	G. W. Steward, Woodsfield	A. R. Burkhart, Woodsfield	2d Wednesday, monthly.
Tuscarawas	C. J. Miller, New Phila.	G. L. Sackett, New Phila.	2d Thursday, monthly.
Eighth District			
Athens	L. D. Nelson, The Plains	T. A. Copeland, Athens	1st Monday, monthly.
Fairfield	W. B. Taylor, Pickerington	C. W. Brown, Lancaster	2d Tuesday, monthly.
Guernsey	M. S. Lawrence, Quaker City	C. C. Headley, Cambridge	1st and 3rd Thursday each month.
Licking	H. A. Campbell, Newark	G. A. Gressle, Newark	Last Friday, monthly.
Morgan	D. G. Ralston, McConnelsville	C. E. Northrup, McConnelsville	3d Wednesday, monthly.
Muskingum	A. H. Gorrell, Zanesville	Beatrice T. Hagen, Zanesville	1st Wednesday, monthly.
Noble			
Perry	Joseph Clouse, Somerset	F. J. Crosbie, New Lexington	3d Monday, monthly.
Washington	S. E. Edwards, Marietta	E. W. Hill, Jr., Marietta	2d Wednesday, monthly.
Ninth District			
Gallia	O. A. Vornholt, Gallipolis	Milo Wilson, Gallipolis	1st Thursday, monthly.
Hocking	H. M. Boocks, Logan	M. H. Cherrington, Logan	Quarterly.
Jackson	J. S. Hunter, Jackson	J. J. McClung, Jackson	1st Tuesday, monthly.
Lawrence	Cosper Burton, Ironton	V. V. Smith, Ironton	1st Thursday, monthly.
Meigs	P. A. Jividen, Rutland	Byron Bing, Pomeroy	1st Thursday, April, July and Oct.
Pike	Paul Jones, Stockdale	L. E. Wills, Waverly	1st Monday, monthly.
Scioto	C. M. Fitch, Portsmouth	Wm. E. Scaggs, Portsmouth	2d Monday, monthly.
Vinton	O. S. Cox, McArthur	H. S. James, McArthur	3d Wednesday, monthly.
Tenth District			
Crawford	K. H. Barth, New Washington	A. E. Loyer, New Washington	1st Monday, monthly.
Delaware	A. R. Callander, Delaware	E. V. Arnold, Delaware	1st Tuesday, monthly.
Franklin	James H. Warren, Columbus	John H. Mitchell, Columbus	1st four Mondays.
Knox	S. O. Gantt, Centerburg	R. L. Eastman, Mt. Vernon	Last Thursday, monthly.
Madison	R. S. Postle, London	G. C. Scheetz, West Jefferson	4th Wednesday, monthly.
Morrow	W. D. Moccabee, Cardington	T. Caris, Mt. Gilead	1st Wednesday, monthly.
Pickaway	A. F. Kaler, New Holland	Lloyd Jonnes, Circleville	1st Friday, monthly.
Ross	Glen Nisley, Chillicothe	W. C. Breth, Chillicothe	1st Thursday, monthly.
Union	E. J. Marsh, Broadway	Angus MacIvor, Marysville	2d Tuesday, monthly.



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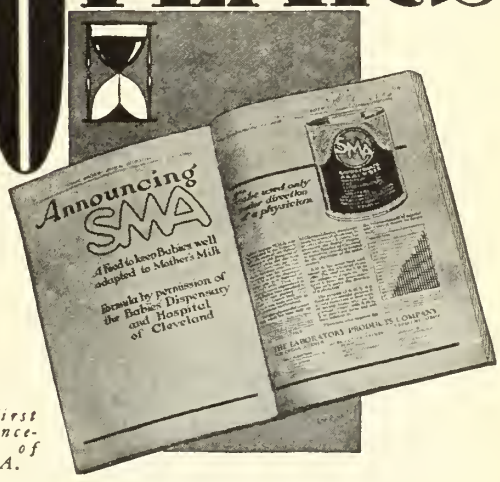
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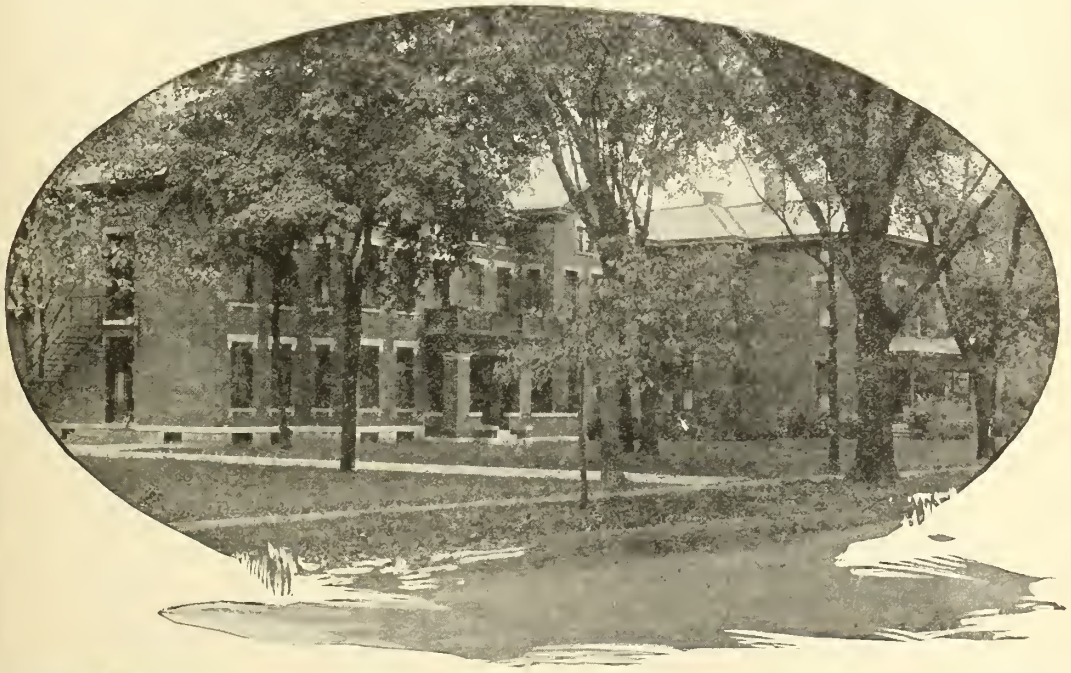
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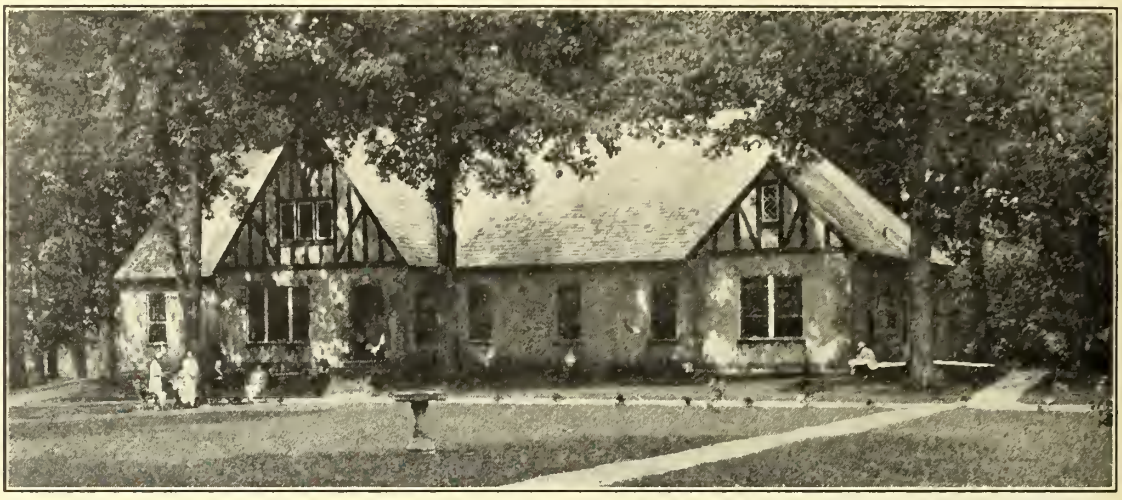
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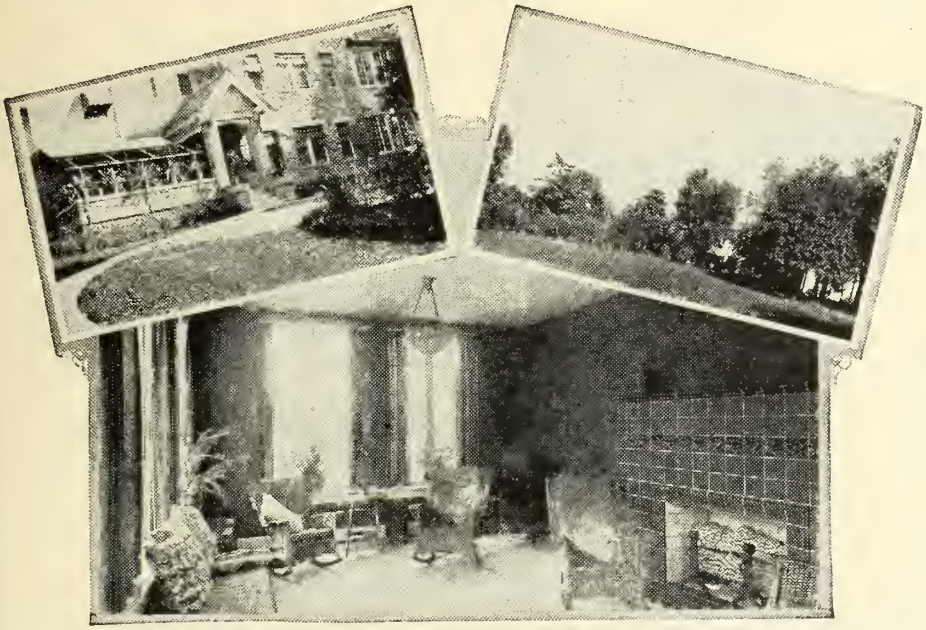
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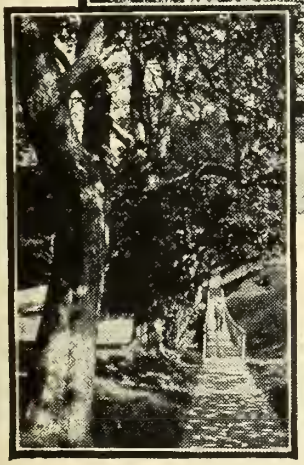
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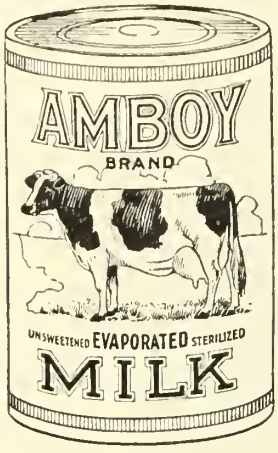


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PUBLIC HEALTH - SOCIAL WELFARE MEDICAL ECONOMICS and ORGANIZATION PROBLEMS

With Editorial Comment by D.K.M.

Elsewhere in this issue of *The Journal* appears the official program for the Eighty-Sixth Annual meeting of the Ohio State Medical Association, to be held Tuesday and Wednesday, May 3 and 4, at Dayton.

Many Attractive Features at the Annual Meeting

From start to finish, the program which has been arranged for the two days' session of the State Association at the Dayton-Biltmore and Miami Hotels is one of the best which has ever been formulated for an annual gathering of the medical profession of the state.

Special emphasis has been placed on the scientific and educational phases of the 1932 meeting as indicated by the well-balanced and varied sectional programs, and the unique and comprehensive symposia to be presented at the General Scientific Session, Wednesday afternoon, May 4, by members of the faculties of Ohio's three Class A medical schools—Western Reserve University, School of Medicine; University of Cincinnati, College of Medicine; and Ohio State University, College of Medicine.

Members of the State Association are respectfully urged to study the program carefully. The annual meeting offers a splendid opportunity for obtaining scientific information on a large number of medical and public health questions.

Special attention of the membership is called to the arrangements which have been made for reduced steam railway fares to Dayton providing a minimum number take advantage of the "certificate plan" offered by the carriers. An article explaining in detail the requirements and how the plan operates will be found elsewhere in this issue of *The Journal.*

For the information of members who have not as yet made hotel reservations for the Annual Meeting, *The Journal* again this month presents a list of Dayton hotels, with their locations, rates and type of accommodations.

The membership also will be interested in detailed announcements of a number of special features of the Annual Meeting, published at the end of the official program. Chief among these are announcements of the Organization Luncheon to be held Tuesday noon, May 3—the first day of the Annual Meeting—at the Hotel Gibbons; the Annual Banquet to be held Tuesday evening, May 3, at the Dayton-Biltmore, when the annual addresses of the President and President-elect will be presented and the membership will be addressed by John B. Kennedy, nationally-known radio broadcaster on the Collier's Hour and a Collier's editor; the medical and surgical clinics which will be given on Monday, May 2, at a number of Dayton hospitals; and the extensive Scientific Exhibit which promises to be one of the principal attractions of the Dayton meeting.

The various committees of the Montgomery County Medical Society have been active in making local arrangements for the gathering and have left nothing undone which will add to the attractiveness of the meeting or provide entertainment for those who will have the privilege of attending. If every physician who can possibly do so, goes to Dayton for at least one day of the two days' gathering, the Dayton meeting will assuredly be one of the most successful and beneficial meetings ever held by the State Association.

Every member of the Association will find the May issue of *The Journal* of vital interest, since it will contain the annual reports of the various committees and officers of the State Association. Many of the important problems confronting the medical profession will be reviewed and analyzed in these reports. They will merit the careful and thorough consideration and study of every member.

Many leaders in medical organization are convinced that the economic, social and governmental developments of the past year will eventually have a stimulating effect on the medical profession as a whole, anomalous as that may seem.

Logical Truthful Thinking

There is little doubt but what events which have taken place since the beginning of the present economic depression have had a tendency to jolt many physicians into a realization that the medical profession is not immune from economic and social changes and that the profession generally has been far too apathetic toward events and developments which are not scientific and professional in character.

It appears now that most physicians have come to realize that the profession must become more alert, active, and even militant if many of the important and fundamental principles on which medical practice is founded are to be safeguarded and conserved. Naturally, there is some disagreement as to exactly what steps the medical profession should take to meet the critical situation which has developed, but the fact that the ma-

jority of the profession has been aroused to a point where it realizes that pressing issues cannot be ignored, and that physicians through medical organization must act, indicates that medicine may be prepared to face the challenges of unrest.

In a recent address before the Medical Society of Milwaukee, Dr. Irving S. Cutter, dean of the Northwestern Medical School, summarizes a few of the issues which are confronting the medical profession, and comments on what medicine must do to solve them.

"Medicine must do its own thinking; not only that, but it must do more thinking and clearer thinking," declared Dr. Cutter.

"Truth and thinking go hand in hand because you cannot think to a logical conclusion without thinking truthfully. We of the medical profession have let others do our thinking for us. We have been willing to sit on the side lines and watch the procession go by.

"Everyone recognizes that economic trends and tendencies are subject to change; furthermore, when applied to society new social alignments result. The physician with his eyes focused upon strictly professional duties suddenly awakens to the consciousness that unrecognized and unappreciated changes in his relation to the public have taken place.

"What can we do to alter this regrettable situation? If medicine is to retain its professional character and not become a trade it is incumbent upon physicians to study intensively all problems relating to education and practice, including economic trends and social tendencies. In order to do this medicine must:

"Develop courageous leadership;

"Develop professional solidarity in thought and conduct;

"Inaugurate a program of public education with a public-relations council or committee in every county society in the United States with a program that is continuous;

"Retain within the ranks of organized medicine only those who are honest with the public and with themselves;

"Develop a faith in the future of medicine based upon its outstanding achievements for public good—a faith that will carry professional wisdom, scientific advancement, and preventive medicine into every community in the land.

"Physicians must be leaders—not followers. We have long been content to adjust ourselves after mass movements affecting our profession have occurred. There should be a sufficient number of thinking minds to plan and put into effect a long-distance program.

"We must muster solidarity, bravery, and courage, and it cannot be done by turning the other cheek. It has to be done by taking positive stands when positive stands are necessary, but it must be done in a spirit of kindliness."

New Problems and Their Challenge

A new public is likely to emerge from the unsettled economic conditions with the return of normal times, students of economic and social questions are predicting.

It is not quite clear as yet just what this "new public" will ask and demand from the business and industrial world. It is less apparent now as to what it will demand from the medical and nursing professions, the hospital, and other agencies that go to make up a well-rounded and efficient medical service.

However, it seems probable that new demands will be made and that the workers in these fields should begin preparing at once to meet the new questions and problems that may arise. No one knows exactly what some of them will be but some of them, undoubtedly, can be anticipated by those with long experience in their particular line of work.

The challenge to the hospital administrator to start getting ready for the approaching period of readjustment is sounded in an editorial published in a recent issue of *The Modern Hospital*, which declared in part:

"New and unusual problems will face the hospital administrator with the return of normal times, and if he is the astute individual that he is supposed to be, he will meet these changes with full knowledge of how to overcome them.

"The fundamental principle that good hospitalization in demand and that people will need the ministrations of hospitals is clearly shown in all communities. That the financial status of patients generally has been lowered has been evidenced in two ways—by a demand for less expensive accommodations and also by the postponement of elective operations.

"The first condition will not be remedied for some time to come, according to all economic authorities, and hospitals must be prepared to provide hospitalization at a reduced cost to the patient. This can be accomplished without much trouble because labor is cheaper and a better type of help is obtainable than has been the case for many years. Raw foods are less expensive and an improvement without an increase in costs can be effected at this time, and there are many other ways of cutting expenses without cutting the service.

"All thought, however, should not be given to cutting costs, but rather serious deliberations should be given to increasing revenue. Some superintendents have supplemented their pharmaceutical services, others have extended their laboratory facilities, still others have increased their occupany by various forms of flat rates and innovations in payment arrangements, such as the installment plan of selling maternity service.

"We see before us a serious problem and at the

same time a wonderful opportunity. Never before has it been so necessary for the hospital administrator to know and understand his community. He should set out at once to make a systematic and thorough survey of all of the conditions in his town and when this is completed he should seek ways and means to meet every phase of the social life of the community and so make his institution the mainstay of the city.

"Every superintendent should be hard at work on a campaign for carefully planned publicity, whereby he can educate the public regarding just what his hospital provides and what it can be used for. More than ever before people are in a receptive mood to learn all about the hospital. The superintendent is the only one who can tell them, but he should have his facts regarding the community and his hospital well in hand before any attempt is made. The wise administrator will survey his community, will plan his public relations program and will meet the new demands of his public."

It is only logical to assume that many of the problems that the hospital executive will be called upon to meet will likewise have an important effect and bearing on medicine and the medical profession.

Will medicine be prepared to meet them?

There is little doubt but what a glance at the future also offers a challenge to the energy and initiative of organized medicine.

Tact Is What Is True, Right And Proper

"I never kept accurate statistics on the subject, but I always felt that not a few of the controversies between doctors and their patients coming to my notice, might have been prevented by a greater display of tact by the physician", writes Lloyd Paul Stryker, former legal counsel for the Medical Society of the State of New York, in a recently published book setting forth the legal rights and duties of the physician in the field of civil and criminal law.

"Tact has been defined", continues Mr. Stryker, "as a 'fine sense of how to avoid offense'. It has likewise been described as 'fineness of discernment as to action or conduct'. Others have spoken of it as an 'intuitive sense of what is true, right or proper'. A fine sense of anything presupposes a sense well developed—an alert and a trained mind. A sense of how to avoid giving offense could only come from a consideration of the rights, the sensibilities, even the prejudices of others. An intuitive sense of what is true, right and proper can spring only from a generous character and sound ethical development.

"Tact is a priceless asset for any professional man; it is indispensable to the physicians. The ills, deformities, physical and mental states of people form the subject matter of his life's work. He encounters all kinds of conditions of men and women, appreciative as well as critical, intelligent as well as ignorant, reasonable as well as unreasonable, fair as well as mean, generous as well as selfish. From the most unpromising of these, he may fashion warm friendships, or sometimes bitter enmities. How he will fare with his patients (granting, of course, reasonable competency) will largely depend upon his sense of tact or on his lack of it."

His advice and suggestions are timely. In this "age of irritability" the medical profession must thoroughly understand the meaning of tact and how to make use of it in its dealings with patients and with the public.

The public is in a jumpy frame of mind. New and unsolved economic questions have accompanied the prolonged economic disturbance. A general spirit of social unrest is prevalent. The costs of illness is a problem of serious proportions to many. The uninformed and misinformed have an inclination to criticize the medical profession, blaming it for many of the economic problems incident to sickness, despite the fact that these questions can only be solved along with other general economic and social problems. Isolated movements to socialize medical practice, under governmental control or otherwise, continue to stir up discontent. It is not overstating to conclude that the public is bewildered about medico-social questions just as it is about all other current economic and social problems.

The future of medical practice may depend in a large measure on how tactful the medical profession, individually and collectively, is, in meeting the issues confronting it. How often it uses a "fineness of discernment as to action or conduct". How well it exercises an "intuitive sense of what is true, right and proper". How much courage it shows in defense of sound economic, social and ethical principles and in assailing those activities and policies which it is convnced will be detrimental to the health of the public and obstruct the advancement of medicine.

Mounting Costs of Government

Although figures are not available for purposes of comparison, it is reasonable to assume that physicians as a group contribute as much toward the operation of government as any other single group of taxpayers in similar financial circumstances.

For this reason, and because it is the business of every citizen to know how and for what purposes public funds are being expended, some of the recent enlightening studies which have been made of governmental

expenditures should be of vital interest to Ohio physicians.

The thing that stands out like a sore thumb in the current controversies taking place at Washington and elsewhere over taxation, balancing of budgets, relief for the needy and unemployed, etc., is the amazing increase which is continuously taking place in the costs of running federal, state and local governments, as evidenced by the searching inquiries which have been made by reliable sources.

In fact, many who have given time and thought to the predicament have reached the conclusion that the greatest single need of the country at the present time is a wholesale deflation of government.

One authority in pointing to the fact that government has grown many times faster than population, cites figures showing that the cost of operating the Federal government alone has increased from less than $700,000,000 in 1910 to approximately $4,000,000,000 in 1932. What is true of the Federal government is equally true, comparatively speaking, of state and local governments.

Not long ago, *The Nation's Business*, one of the most energetic crusaders for deflation of government, presented a few statistics which make it easy for the physician to understand why Congress is scratching its head over the question of balancing the Federal budget and how much it must hike the Federal income tax rates.

The costs of certain activities of the Federal government for 1925 and 1932 were listed as follows:

Board of Tax Appeals, $350,000 in 1925; $660,000 in 1932.

Bureau of Efficiency, $150,000; now $200,000.

Civil Service Commission, $1,000,000; now, $1,500,000.

Employes Compensation Commission, $2,250,000; now, $4,500,000.

Federal Board of Vocational Education, $5,500,000; now, $10,000,000.

Federal Farm Board, did not exist in 1925; now, $1,500,000 exclusive of advances for purchase of farm commodities.

Federal Power Commission, $30,000; now, $300,000.

Federal Radio Commission, did not exist in 1925; now, $400,000.

Interstate Commerce Commission, $4,000,000; now, $9,000,000.

Federal Trade Commission, $1,000,000; now, $1,800,000.

Tariff Commission, $700,000; now, $1,250,000.

Veterans Bureau, $300,000,000; now, $735,000,000.

Bureau of Animal Industry, $10,000,000; now, $16,000,000.

Bureau of Dairy Industry, $450,000; now, $800,000.

Bureau of Plant Industry, $3,600,000; now, $5,800,000.

Forest Service, $10,000,000; now, $20,000,000.

Bureau of Chemistry, $1,400,000; now, $2,000,000.

Bureau of Entomology, $2,000,000; now, $2,800,000.

Public roads, $13,000,000; now, $125,000,000.

Bureau of Agricultural Economics, $4,500,000; now, $7,250,000.

Home Economics, $100,000; now, $250,000.

Bureau of Standards, $1,750,000; now, $2,750,000.

Bureau of Foreign and Domestic Commerce, $2,700,000; now, $5,250,000.

Bureau of Fisheries, $1,300,000; now, $3,000,000.

Bureau of Aeronautics, $500,000; now, $10,000,000.

Bureau of Immigration, $4,500,000; now, $10,000,000.

Bureau of Naturalization, $700,000; now, $1,100,000.

Women's Bureau, $100,000; now, $150,000.

Employment Service, $200,000; now, $900,000.

The article also compares the total costs of the major departments for 1925 and 1932 as follows:

Agriculture, $155,000,000; now, $243,000,000.

Commerce, $25,000,000; now, $50,000,000.

Interior, $83,000,000; now, $85,000,000.

Justice, $22,000,000; now, $50,000,000.

Labor, $8,000,000; now, $14,000,000.

Navy, $330,000,000; now, $360,000,000.

State, $16,000,000; now, $17,500,000.

Treasury, $147,000,000; now, $267,000,000.

War, $340,000,000; now, $330,000,000.

One observer who had made a careful study of similar statistics, commenting on the startling facts he had uncovered, said:

"There's an increasing and insistent demand that taxes be reduced. What stands in the way?

"The fact that the very men and women who want taxes reduced don't want government expenditures cut. That is, they don't want their own pet expenditures cut.

"Some time ago, I asked this question bluntly of Representative Will R. Wood of Indiana:

" 'Is there any way of reducing government expenditures?'

"His answer was:

" 'No, except in the Army and Navy. If you try to reduce the expenditures of government departments you meet too much organized opposition in Congress.

" 'There is too much 'If you'll help me save this for my constituents I'll help you save that for yours.'

"This is the great obstacle in the task of making government cheaper."

These are a few reasons why Ohio physicians are being compelled to dig deep, even until it hurts.

Whether the revolt which has been initiated against government growth will bear any fruit is of course problematical. At any rate, it deserves serious consideration.

Premature Infants

A Report of Eleven Hundred and Twelve Consecutive Cases*

JULIUS H. HESS, M.D., and EVELYN C. LUNDEEN, R.N., Chicago, Ill.

IN the period from 1922 to date, 1112 infants prematurely born and infants immature as the result of multiple pregnancies were admitted to the Premature Infant Station at the Sarah Morris Hospital. Included in our statistics there were eighty-two who weighed over 2500 grams when admitted. These, however, showed distinct stigmata of prematurity. We have also included some very small infants, in most instances the product of multiple gestation, who were born at or near term, but were decidedly immature. The term, immature infants, might well apply to both these groups of infants because of similar indications presented for their feeding and care. In addition to these cases we have many readmissions due to illness on the part of our graduates and also receive a limited number of full term infants who are in need of special care which can best be given by the nursing force in charge of the Station. Neither of these two latter groups are included in the statistics which are here presented.

The growing importance of the subject is indicated by the increase in the number of infants recorded as premature during recent years. Of 2806 deaths of infants occurring in Chicago during one year, 739 deaths in the first month of life were due to prematurity. Of 860 who died during the first twenty-four hours, 399 deaths were due to premature birth, while of 1700 who died during the first week of life, 588 deaths were due to premature birth.

In the United States the care of premature infants has not received the general attention of the medical profession which it merits. Hospital facilities for the care of such infants are lacking; first, because special obstetrical hospitals in most instances decline outside cases, and, second, because comparatively few general hospitals are properly organized to undertake the special care required.

In a study of premature and congenitally debilitated infants, at least two factors in the life history of the fetus must be considered:

1. The term of intra-uterine life. The younger the fetus when it leaves the uterus, the greater the difficulties to be overcome in carrying out the body functions necessary to life and, therefore, the lower its vitality. Biologically, age must be reckoned from the time of conception rather than from birth.

2. The state of its functional development at birth, as evidenced by the presence or absence of inherited disease. Full consideration must be given in the case of each individual infant to the causes in the parents, and the infant as well, which might lead to premature delivery or poor physical development.

MORPHOLOGICAL AND FUNCTIONAL CONSIDERATIONS

Feature Stigmata. The appearance and characteristics of the healthy premature child vary with the fetal age at the time of birth.

With increasing age, the characteristics become less marked until the picture eventually merges into that of the full term infant.

The early small, thin face with its mass of wrinkles in the presence of proper feeding soon becomes rounded out by the deposit of layers of fat, the skin becomes smoother and the face more nearly like that of a normal nursling. There remains, however, for a more or less indefinite period, a prominence of the sucking cushions greater than that seen in the normal infant. The enlargement of the tongue may be noted until toward the end of the first year. The same may be true of exophthalmos. The small stumpy nose may also retain its characteristic appearance until the end of the first year. The "doll" type of face is also usually present until after the fourth or sixth month of life.

Thermolability, the inability to regulate and maintain a normal body temperature, is due to diverse factors. Among these, incomplete development of the heat-regulating center and intracranial injuries are the most important. The relatively large body surface, the extensive vascularization of the skin and the thinness of its epidermal layers, and the meager subcutaneous deposits of fat all predispose to excessive loss of heat through radiation. Physiological loss of weight, due to dehydration, and inability to retain and metabolize sufficient food to meet their needs are other factors.

Blackfan and Yaglou[1] determined the temperature and humidity requirements for the various groups of premature infants over a period of four years by so adjusting the temperature conditions in two adjoining rooms and in electric incubators that fluctuations in body temperature were minimized. From observations on body temperature, gain in weight, incidence of diarrhoea, mortality and general behavior of the infants under various humidity conditions, a relative humidity of 65

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From the Premature Infant Station, Sarah Morris Hospital for Children, Michael Reese Hospital, and Nelson Morris Research Institute, Chicago, Ill. This station is endowed by the Infants' Aid Society, Chicago, Ill.

We wish to acknowledge the courtesies extended by Doctors A. Levinson, Mark Jampolis, and J. R. Gerstley in granting permission to report the cases occurring on their respective services.

per cent was adopted. They found that relative humidities less than 50 per cent were distinctly harmful to the prematures. They affected the stability in body temperatures, diminished gains in weight, and increased the incidence of diarrhoea and mortality. Continuous exposure to air conditions with 55 to 65 per cent relative humidity, on the other hand, gave very satisfactory results. In our station we keep the infants in heated beds in an open, well ventilated room. Under such conditions we have found that an average relative humidity of 45 per cent gives satisfactory results.

An interesting observation is the readiness with which the normal infants perspired in the conditions of high temperature as compared with the delayed perspiration of the premature infants.

Initial Weight Losses. Loss of body weight during the first days of life occurs so constantly in full term infants that moderate losses must be considered physiological. This is also true of premature infants although in most instances it is relatively greater. Premature infants lose relatively more and regain their birth weight more slowly, often requiring a month and also, as a general rule, the nearer the prematures are to full term, the lower is the relative loss of weight as expressed in percentages. The loss in weight in premature infants should not average more than between 7 and 8 per cent of the birth weight.

THE DIGESTIVE TRACT

Anatomy. The muscles of the buccal region of the tongue and of the soft palate are weak.

The stomach of the premature infant before its first feeding, as seen in autopsy, is in an almost vertical position and tubular in its form. In the premature infant which has been fed, the fundus is fairly well developed and causes the stomach to assume a more oblique position. This is corroborated by a roentgen-ray examination.

The cardiac end of the stomach is found well to the left and usually about the level of the tenth dorsal vertebra. The cardiac sphincter is usually poorly developed. This in part accounts for the ease with which the premature infant regurgitates its food. The pylorus lies somewhat higher than that of the full term new born, in whom it is found about midway between the ensiform cartilage and the umbilicus. Before feeding it is almost always found to the left of the median line. The pyloric musculature is usually quite well developed, even in the new born premature.

Gastric Capacity. Although many authors have measured the full term infant's stomach as to its capacity, both at autopsy and in the living, their figures vary considerably.

In a post mortem study of 34 stomachs under pressure of a column of 15 cc. of water, I estimated the average sizes of fetal stomachs as follows:

24	weeks—	5 cc.
26	"	— 8 cc.
28	"	—10 cc.
32	"	—18 cc.
36	"	—25 cc.
40	"	—45 cc.

The stomach of the premature infant on a diet of breast milk is usually found empty at the end of one and one-half to two hours. That of the artificially fed requires a considerably longer period of time, depending upon the nature of the food administered, even in the case of feeding with predigested milk.

CARE AND NURSING OF PREMATURE INFANTS

In the management and care of premature infants, definite essentials should be kept in mind. An endeavor should be made to approximate their surroundings as nearly to the intrauterine conditions as possible. They must be protected against exposure from the moment of birth. The surrounding temperature must be relatively high with minimum fluctuations. A fairly constant relative humidity should be maintained and provision for a daily free circulation of air must be provided. They must be protected from all shocks, physical and nervous, and their nutriment must be supplied in form and quality most easily assimilable.

HOME CARE

A careful consideration of the requirements in the home is essential for good results. In many instances the premature is born unexpectedly with little time for preparation for its reception. The expectancy of a premature labor is almost always associated with more or less excitement in which thought for the baby's needs are likely to be overlooked, the mother usually being given first consideration.

In the home care of these infants the same rules for hygienic maintenance of body temperature, breast feeding and daily routine must be maintained as suggested for their hospital care.

FOOD AND METHODS OF FEEDING

The question of when to start regular feedings is of great importance to these infants because of the tendency to develop acute inanition. Therefore, a regular feeding regimen must be started early.

Human milk is essential to a low mortality. However, in many instances breast milk is not available during the first days of life and unless regular stimulation of the breasts by expression or pumping is practiced, the milk may permanently remain insufficient to meet the infant's needs.

Artificial Feeding. In the feeding of premature infants there can be no comparison between the results to be expected from human milk and those to be obtained with artificial food. This is

especially true of infants with a weight below 1500 grams. Many varieties of artificial diet have been suggested by different clinicians such as simple fresh, evaporated, dried, reconstructed or condensed milk dilutions or buttermilk preparations. To these diluted mixtures carbohydrates are added. The results with these various diets are to a great degree dependent on the physician's intimate understanding and directions for use of the individual food.

Additional Foods: To counteract the effects of boiling, the feeding of orange juice should be instituted by the third week beginning with five drops daily and increasing to two tablespoonfuls twice daily by the end of the eighth week.

Cod liver oil, as an antirachitic, should be fed before the end of the third week beginning with two drops daily and increasing to sixty drops daily by the eighth week. It is best divided into two feedings. Viosterol has been used in a considerable group of our infants, starting with two drops daily and increasing to fifteen drops daily by the eighth week, using the preparation standardized to 250 times the vitamin D content of cod liver oil. It is our impression that the infants show better progress when it is used in combination with cod liver oil.

To meet the iron requirements of these infants, raw egg yolk may be added to the diets of both breast and artificially fed infants, in the amount of one yolk to each quart of milk. If eggs of good quality are not available, one-half grain doses of carbonate of iron or iron and ammonium citrate daily may be used. Either the egg yolk or iron should be introduced into the diet by the fourth week.

Ultra Violet Irradiation: As early as the third week infants can be exposed to ultra violet rays with the quartz or carbon arc lamp. The time of exposure varies with the indications in the individual case. At first these exposures should be limited to fifteen seconds with the distance varying with the type of lamp. It is rarely necessary to give more than two minute exposures three times a week. Over exposure may result in irritability, vomiting and increased body temperature. The dose also varies with the amount of viosterol and cod liver oil fed.

OUTSTANDING CLINICAL PATHOLOGY

A careful record was made of the pathological findings in 399 of the infants in our premature ward at Sarah Morris Hospital.[2] Each of the pathological entities was listed according to the number of infants in whom it was reported. Many of the infants had several of the conditions recorded.

Cyanosis was the most frequent pathologic finding noted in the station. It was present in 138 infants, of whom 85 died. The cyanosis varied in degree from the extreme purple of infants with marked atelectasis to the slight degree of blueness noted occasionally during or after feeding.

In a special study of the appearance and course of cyanosis in 102 of our group of infants, marked cyanosis was observed in 53 (51 per cent) of these cases—46 of the infants died. Only two of the infants who died did not exhibit cyanosis at some time during the course of the illness. In the infants who lived, cyanosis occurred as a single attack or as an occasional attack associated with some demonstrable cause such as hypothermia, hyperthermia, vomiting during feeding or the presence of abdominal distention, diarrhoea and infection. Temporary attacks of a minor degree are not an uncommon sign in the premature infant who survives.

Treatment. A premature infant must be carefully watched for signs of cyanosis, otherwise it may be found dead in bed.

It cannot be too strongly emphasized that the manipulations used to relieve the cyanosis should be the minimum necessary to accomplish the result as cyanotic infants react poorly to trauma.

The prevention of cyanosis may be aided in several ways. The too rapid taking of food or distention of the stomach by overfeeding must be avoided. Underfeeding in cases where too frequent feeding is undesirable can be avoided by catheter feeding at longer intervals, although the maximum food quantities must be carefully ascertained by starting with minimum feedings, carefully increased according to the infant's tolerance. Catheter feeding is not well borne by all infants and may occasionally in itself induce cyanosis.

Should an attack occur while the child is being fed, the proceeding must be stopped and efforts made to restore respiration. Holding the infant in an inverted position often serves to clear out the respiratory tubes and when followed by cutaneous stimulation through friction or gentle slapping is often enough to reinstate breathing. Sprinkling the baby with cool water will occasionally stimulate respiration and as this means is always at hand it should be kept in mind.

Exhaustion of the infant may be solely responsible for the cyanosis. Simple compression of the chest may be tried without removal from the incubator or bed, though removal will be found more serviceable generally. The use of oxygen is of value in quickly reducing the degree of asphyxia after breathing is once established, although it will not of itself restore that function. Its continuous use when properly applied is advocated as a valuable measure in the checking of attacks. A modification of the Hess bed for continuous administration of oxygen will be described later. Aromatic spirits of ammonia in one-half to two drop doses, diluted, is of value, and nitroglycerin, one drop of a 1:1000 solution may be placed on the tongue. The use of camphor, caffein,

atropin or other respiratory stimulants hypodermically does not offer much practical help.

Apathy of marked degree was present in all infants who died, especially those in the group with intracranial hemorrhage. It was present to a lesser degree in small and debilitated infants.

Fever. Sixty-five per cent of those infants having infections showed little, if any, rise in body temperature. The infections were chiefly those of the upper respiratory tract, otitis media, pyelitis and pneumonia. A rise in temperature does not necessarily occur as a symptom of infection as some of the most severe examples had a normal or subnormal temperature. Subnormal temperatures are often indicative of a poor prognosis, especially in smaller infants.

Jaundice of severe type is a frequent symptom in the premature. There are two types of severe jaundice—that which occurs during the first two weeks of life and that which becomes increasingly evident during or after the second week. In the former, among our fatal cases, intracranial hemorrhage complicated by infection, was a frequent combination. In the second group, infection appeared to be the predominating factor.

Vomiting. Severe and persistent vomiting may be present in cases of intracranial hemorrhage, more especially of the infratentorial type and in systemic infections. Abdominal distention, gastric irritability and pylorospasm may all result in repeated attacks. Toxemia of pregnancy is a common cause of vomiting in the fetus. About 75 per cent of all prematures regurgitate some feeding during the first three days.

Vomiting is treated by an immediate decrease in feeding. Feeding should be decreased to the point where the infant retains all of its feeding. The feeding is again increased *very* gradually. It is sometimes advisable to discontinue water between feedings until vomiting ceases. Infants who vomit often do better on small concentrated feedings than on diluted milk mixtures. While on a concentrated diet, water or tea should be given between feedings. Abdominal distention is always looked for in any premature who is vomiting and if present is relieved either by enema or lavage. Following lavage a short period of starvation without fluids, followed by small feedings of 5 per cent glucose solution at regular intervals, often results in lessened gastric irritability. A change from the mother's milk to that of more mature milk from another woman may be necessary. Artificial feeding will be discussed later.

Diarrhoea is a frequent occurrence in the premature infant and always calls for careful judgment in their feeding regulations in order to avoid dehydration and inanition.

The infant is starved from 12 to 24 hours depending on the severity of the diarrhoea. Weak tea or one-half strength Ringer's solution is given by mouth (one-third to one-fifth of body weight) during 24 hours. The baby is fed every 30 to 60 minutes if necessary. If unable to give a sufficient amount by dropper or bottle, the infant is gavaged for 24 hours.

Feedings are then started. The premature is fed every three hours, starting with a very small amount, 3 to 8 cc. usually, of one-half skim lactic acid milk and one-half breast milk. If no breast milk is available, undiluted skim lactic acid milk is given. No carbohydrates are added.

Feedings are increased by 2 to 5 cc. as the infant's reaction to the increased diet warrants. During this gradual increase, from 30 to 60 cc. of tea are given between each feeding.

We have found 6 to 15 cc. of whole blood given intramuscularly to be of great value in these dehydrated and toxic infants. It is usually given daily or every second day. Saline solutions given subcutaneously have been largely discontinued since we have adopted feeding with weak tea or Ringer's solution in large amounts.

Twitchings (indefinite symptoms) occurred at times in infants suffering from various conditions. Numerically they were not more frequent in the cases in which hemorrhage occurred than in the others. This was probably explained by the early death among the patients with severe intracranial hemorrhage.

Generalized convulsions in the very young infants are most often due to intracranial hemorrhage and infection. Anoxemia and gastro-intestinal upsets rank next in importance. In older prematures, tetany should always be thought of as a possible cause since this condition develops at a much earlier age in the premature than in the full term infant.

Congenital syphilis was diagnosed in only 5.5 per cent of 1041 cases, notwithstanding the fact that a Wassermann test was made in one or both parents with few exceptions. Positive diagnosis of syphilis was established in 36 cases of whom 15 died. Eleven showed no outstanding clinical signs. While the percentage of proved syphilis was very low, the mortality among these infants was exceptionally high.

Cerebral hemorrhage was diagnosed in 119 infants either clinically or at autopsy or both. Twelve of these infants recovered. It is interesting that among the large group of infants visiting our clinic for station graduates, only six show marked evidence of mental deterioration. Out of 246 infants who came to autopsy, 107 had intracranial hemorrhage, (43 per cent). The location of the hemorrhages was as follows: Supratentorial thirty-three, infratentorial forty-five, intraventricular ten, subarachnoid five, and diffuse hemorrhage thirty-two. The discrepancy in figures is due to some of the cases having hemorrhages in more than one region.

Saenger[3] found macroscopic intracranial hemorrhages in seventy-three of 100 new born infants cadavers. The tentorium was intact in only three of forty-six with much hemorrhage and in fifteen of the twenty-seven with slight hemorrhage.

Framm[4] gives intracranial hemorrhage as the most frequent cause of death. It was present in 24 per cent of his cases.

Yagi[5] found 34.3 per cent in his cases.

Meningitis was diagnosed in six infants, all of whom died.

True hydrocephalus was diagnosed in five infants of whom two died before leaving the station.

Megacephalus was a frequent clinical finding which gradually disappeared with the infant's development. The conception of the megacephalus of the immature infant is credited to Yllpö[6] who explained it by saying that the brain continues to grow independently of the rest of the body and reaches its normal size but because of slow growth and development of the body, the head seems disproportionately large. In other words, the head is normal but the body is subnormal in size. It is possible, however, that the megacephaly of the later months is a summation of the effects of immaturity and of rickets.

Enlarged thymus. In 104 autopsies in which special attention was paid to the thymus gland, only five cases were reported as showing marked hypertrophy.

CEREBROSPINAL FLUID OF PREMATURE INFANTS

In the study of the spinal fluid in intracranial hemorrhage of the new born,[7] premature infants offer perhaps the best material as subjects of investigation, not only because intracranial hemorrhage occurs so frequently in these infants but also because permission for postmortem examination is more easily obtained than in any other class of hospital patients. The latter is important if clinical observations are to gain significance by correlation with subsequent observations at necropsy.

The presence of red blood cells in microscopic numbers in the cerebrospinal fluid of premature infants during the early days of life is so common that it may be considered as a physiologic phenomenon. At lumbar puncture, it is not always possible to distinguish between fluids bloody as the result of congestion and fluids which contain blood as the result of intracranial hemorrhage.

In a series of 35 cases of cerebrospinal hemorrhage or acute meningeal congestion proved by necropsy, the cerebrospinal fluid obtained by lumbar puncture was grossly bloody or hazy in twenty-eight cases, or 80 per cent.

In a series of forty-two cases in which evidence of meningeal hemorrhage was not found at necropsy, the spinal fluid was grossly bloody or hazy in thirteen, or 31 per cent, of the cases. This percentage is sufficiently high to indicate the danger of making a diagnosis of cerebral hemorrhage on the basis of blood spinal fluid withdrawn by lumbar puncture alone.

Meningeal congestion alone may be the underlying cause.

It was also shown that clear spinal fluid may be obtained in certain cases of subpial hemorrhage.

Crenated red blood cells in cerebrospinal fluid were regarded as cells which were in the fluid prior to the time of the lumbar puncture at which they were obtained.

Cerebral hemorrhage probably contributes to the degree of icterus neonatorum and unrecognized cerebral hemorrhage is perhaps the cause of some cases of so-called physiologic icterus neonatorum.

RICKETS, ANEMIA, TETANY AND SCURVY

Rickets. Not only is rickets a common disorder of prematures but it appears much earlier in these little infants than in full term. In our experience severe forms have been reduced to a minimum by judicious feeding, daily introductions of cod liver oil and viosterol into the diet and the use of ultra violet therapy.

Anemia. Closely associated with rickets in prematures is an anemia which develops quite regularly during the first three months of life. Unless very early preventive measures are instituted there is a distinct hemoglobin impoverishment in the blood which reaches its maximum in about the third or fourth month. In some instances even these measures fail due to a hypoplastic condition of the hematopoietic system. Diet and lack of sunshine also play a large role.

Tetany. Typical attacks with all of the characteristic manifestations such as the phenomeno of Erb, Chvostek and Trousseau carpopedal spasms, tonic and clonic convulsions and laryngospasm are but rarely observed in premature infants. Hyperirritability and convulsions are the most common manifestations and are frequently seen as early as the second to the fourth month. In the majority of cases the disappearance of the symptoms occurs simultaneously with the disappearance of the craniotabes and improvement of the anemia.

Scurvy. Acute florid cases presenting all of the classical findings—malnutrition, secondary anemia, hyperasthesia together with subperiosteal hemorrhages and hematuria are only occasionally seen. Far more common are the subacute or latent manifestations, characterized by an insidious onset evidenced by lack of gain in weight, anorexia, irritability and progressive anemia. These latent cases are often overlooked. General improvement following the introduction of antiscorbutic dietetic measures confirms the diagnosis.

Thus it becomes more and more apparent that anemia, rickets, tetany and scurvy in the prematures have largely a common background.

PROGNOSIS AS TO LIFE

In estimating the outlook for an infant born before the natural termination of the normal period of pregnancy, one must consider the prenatal and the postnatal factors before arriving at a conclusion. Of prenatal influences, the most important are the fetal age, the physiological development and absence of constitutional anomalies, transmitted parental conditions and the presence of malformations. Of postnatal conditions the occurrence of any of the various diseases of the new born affects the prognosis. In addition to these, the time at which the infant is received for treatment and the character of the treatment it receives are determining factors in the probable outcome. The prognosis becomes better as time passes in proportion to the care the child receives with respect to its hygiene and feeding. The secret of success in raising the premature lies in avoiding refrigeration and infection and in the proper selection of food as regards quality, quantity and method of administration.

Of 1112 infants admitted to our station, 805 lived and were transferred to their homes. This represents 72.4 per cent. If we exclude the patients who died in the first twenty-four hours, 80.8 per cent survived. The high mortality of the first twenty-four hours, in a large part due to birth trauma and immaturity, is influenced greatly by outside factors such as previous care and transportation.

At the present time, of the 805 graduated infants, 375 are in attendance at our clinic for graduates; 82 others have been transferred to the care of their private physicians and 21 are out-of-town patients. We have records of the deaths of 76 after discharge from the hospital or on readmission.

PHYSICAL DEVELOPMENT

To be answered satisfactorily this question must be considered from several angles. First, the relation of mortality to the different age periods up to the time of puberty and, second, the effect of premature birth on the mental and physical development of the child.

We may look for our best results during the first months of life in the premature born without physical defects, from healthy parents and one who has been able to take ample breast milk from its mother or a wet nurse. Similarly, in such an infant we may expect a good response to artificial feeding when it becomes necessary to discontinue the breast. This group will also show a resistance to infection which compares favorably with that of a full term infant.

In the course of a few months, characteristic changes appear. The slender body becomes short and stocky owing to the gradually thickening neck and a general rounding out of thorax and abdomen. The head increases in size, the face is filled in by fat deposits and development of the muscular "sucking pads" in the cheeks occurs. Exophthalmos is a common finding and the nose may lag in its development. The face assumes the "doll type." Although there is this increased growth in the head and trunk, the rate of growth in the extremities remains retarded.

The presence of early rickets and spasmophilia, together with the secondary anemia which so commonly accompanies these conditions, will leave their inhibiting impress upon growth and development during early childhood. As advised, prophylaxis against their appearance is imperative in well directed care of prematures.

In most children from the second or third year there begins a gradual equalization so that by the fourth to the sixth years the curves of growth run parallel with those of full term children. Therefore, in the presence of organs sufficiently mature to carry on the normal physiological requirements of circulation, respiration, metabolism and excretion and with nervous and endocrine systems sufficiently stabilized to coordinate the various body functions, normal body growth and mental development are to be expected.

Early defects gradually disappear and in by far the larger percentage of cases of those who survive, the differences between the premature and the full term child have disappeared by the time of puberty.

MENTAL DEVELOPMENT OF PREMATURE INFANTS

The mental development of children born prematurely has, as evidenced by the literature, had very limited study. Physiological reports are meagre and offer widely divergent opinions.

A study of the older graduates from the clinic for prematurely born children, conducted by Mohr and Bartelme, at the Sarah Morris Hospital for Children, in order to evaluate the mental development of a considerable group of these infants, was undertaken. The station has now been in operation for nine years and, therefore, a number of these children are old enough to afford a comprehensive analysis. It was the object of this investigation to draw a true cross section of the mental age of the infants and every effort was made to prevent discrimination in favor of the better types. In the group over four years of age every available child was brought into the investigation.

One hundred and thirteen white infants and children prematurely born were studied in order to determine whether the mental development of prematurely born children deviated from that of full term children. This group was compared with forty of their full term siblings.

Birth weights for the prematurely born group

ranged from 907 gm. to 2,500 gm. (mean = 1,921 gm.) Fifty-one boys and sixty-two girls were included. There were seventeen sets of twins and seven surviving members of twin births in the group. The chronological age at the time of examination ranged from eight months to seven years (mean age, two years and nine months). The chronological age corrected for the period of prematurity was used as the basis of estimate of performance. All children were similarly classified by utilization of the Kuhlmann-Binet test. According to the Gesell ratings, 43 per cent of the children were classified as average, 35 per cent as below average and 22 per cent as above average. According to the Kuhlmann-Binet test, approximately two-fifths of the children were of average intelligence, two-fifths were of superior intelligence, and one-fifth were below average intelligence. Three of the children, aged eleven months, seventeen months and forty-eight months, were mentally defective.

In "personal-social" behavior, the performance of the children was consistently relatively superior. This may be attributable to the unusual care and attention offered prematurely born children or to their additional opportunities for social experience. In motor performances the children were relatively poor. Those children who weighed relatively more at birth tended to do better on these tests.

The mean mental age of the forty siblings exceeded their mean chronological age by 1.2 months; the mean mental age of the prematurely born children exceeded the mean chronological age by two months. The full term siblings tended to cluster more about the average ratings, while the prematurely born diverged above and below.

A comparison of performances of fifty individual prematurely born children with those of their forty full term siblings, on the basis of the relation of mental age to chronological age in each case, revealed no significant difference in the mental development of the two groups, if due allowance was made for the period of prematurity.

The prematurely born children did not differ from full term children in the time of the beginning of eruption of teeth, in onset of walking, in beginning of talking and in the learning of bladder control, if correction was made for the period of prematurity. The smaller prematurely born children were consistently a little later in these developments, but again the difference was minimized if this correction was made.

Twenty-eight of the 113 prematurely born children were cyanotic, had convulsions, or otherwise gave evidence of possible intracranial hemorrhage or injury of the central nervous system at birth. Twelve of these children showed no noteworthy deviations on present physical examination, five others showed some disturbance of the reflexes, and the remaining eleven presented various observations. Three of the latter were mentally retarded.

Seven children without early history or evidence of hemorrhage or injury of the central nervous system at birth presented physical observations related to the central nervous system. Of these, four were spastic to some degree. One of the spastic children was of borderline defective intelligence type. This group of seven children, a group of nine children who evidenced strabismus only, and fourteen children who presented heart conditions, contained fewer of the superior children than groups selected on other bases.

Hemorrhage and other injury at birth result in consequences to prematurely born children that do not differ from those clinically noted among children born at full term. If they occur more frequently among the prematurely born, they constitute an extra hazard of prematurity.

SOCIAL SERVICE AND FOLLOW-UP CLINIC FOR GRADUATES

The mothers of the graduated infants, artificially fed, are given instruction in the preparation of the feeding by the dietitian in the hospital milk station and in the routine care of the infant by the nurse in charge, before the infants are discharged. Following their discharge, the social service nurse visits the infant in the home. As soon as the infant's condition permits, in the case of those infants not under observation by a private physician, the mothers are encouraged to bring them to the hospital clinic for graduate infants. The infants are weighed, examined, and the necessary instructions given as in any other infants' clinic. Exposure during examination is avoided. As the infants grow older, longer intervals between visits (four or six weeks) are allowed. After reaching the age of two years, they are transferred to the infant clinic at the Michael Reese Hospital Dispensary.

It is to be remembered that our clinic is chiefly concerned with the babies whose parents cannot afford private care and who are needful of close medical supervision. Over seventy-five per cent of our cases are of the charitable type as seen in a large city. It has been our endeavor to return for study every child over two years of age who can be located. Apparently nature has wisely removed most of those not fitted to survive.

DISCUSSION

H. J. GIRSTENBERGER, M.D., Cleveland:—I wish very much to compliment Dr. Hess upon the contents of his contribution and Dr. Mohr upon the excellent manner in which he presented the material. I agree with the authors in their listing of the factors of importance in successfully rearing premature infants. Probably the greatest credit for the increased success in caring for premature infants belongs to the progress which we have made in feeding premature infants. At the Babies and Children Hospital, Drs. Nourse and Russell particularly have been caring for this type of infant and they have succeeded in obtaining very

remarkable results by feeding the infants cautiously and rather meagerly during the first two weeks and then, when they have indicated that they can take care of the food offered, by increasing the number of calories to 120 to 150 per kilo. They have also had the interesting experience of finding that one mixture in our hands has been distinctly superior to any other. The infants have been fed concentrated breast milk, two parts concentrated liquid S.M.A., one part boiled skim milk and one part water; casein milk; and protein S.M.A. The last named has been the successful combination and it may be that its high content of the water soluble B and water soluble C Vitamins has played a role in bringing about this excellent result.

DONALD C. MEBANE, M.D., Toledo:—Dr. Hess and Dr. Mohr have been working for several years on the physical and mental status of the premature infant. They have shown that provided the premature is far enough along so that his organs are anatomically normal and has not been injured by severe trauma at the time of birth he will eventually be practically the equal mentally and physically of the full-term infant.

This viewpoint is welcome to the pediatrist for it justifies the study and effort he has spent in the care of the premature infant even though convulsions, cyanosis and other symptoms occur. The obstetrician will be of great help to the pediatrist if he will endeavor to postpone delivery in the effort to carry the infant along as far past seven months as possible.

Dr. Richard Scammon, the anatomist, who is particularly interested in fetal and child anatomy, has shown that the length of the fetus, premature or full term infant, is the most accurate method of determining the exact age. He has worked out a formula by which this may be calculated. Calculation of age by weight or by the menstrual periods is far more variable and less reliable.

Pediatrists owe a debt of gratitude to Dr. Hess and Dr. Mohr who have given us a new viewpoint regarding prematurity and all the more because it is an optimistic one.

GEO. J. MOHR, M.D., Chicago:—Study of the prematurely born infants described by Dr. Hess serves to clarify certain moot points with respect to the potentialities of the prematurely born. A glance through the medical literature on prematurely born children indicates that control observations are not recorded which would tend to make clear the facts relative to this point. It would appear from the material that has just been presented by Dr. Hess that under optimum conditions for physical development most prematurely born children tend to overcome the handicaps inherent in the condition of prematurity. It would appear that statements to the effect that they contribute largely to the feebleminded and psychopathic population are not warranted. To be sure, the secondary hazards of prematurity are rather great. Mortality is high; the blood vessels are poorly developed and tendency to hemorrhage is great. As a result of this, there is that definite small group who are rendered mentally defective or show other evidence of central nervous system injury resulting from hemorrhage. Too, the immature state of development of the gastrointestinal tract and the immaturity of the hemapoetic organs contribute to the difficulties that must be faced by the prematurely born infant. Granted there is no gross damage, however, Dr. Hess' tables indicate that the prematurely born infant does proceed to develop in a manner that does not differentiate him in appreciable degree from his full-term sibling. Obviously, effort to improve methods and means of dealing with this class of infants is warranted on the basis of the results that can be obtained and potentialities that these children manifest.

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Extra-Systoles and Their Treatment With Quinidine Sulphate

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THE purpose of this communication is to emphasize the specific influence which quinidine sulphate often exerts in the control of extra-systolic arrhythmias.

The value of quinidine in the treatment of properly selected cases of auricular fibrillation and flutter has received widespread recognition, and it is generally appreciated that the drug may prove of life-saving importance in the control of paroxysmal tachycardia.

For some peculiar reason relatively little interest has been shown in the therapeutic use of quinidine in the abolition of premature contractions. This attitude is, perhaps, the result of the well known statements of MacKenzie[1] and Lewis[2] that extra-systoles are of little practical significance. However, P. S. Barker[3] in a statistical study suggests that this type of irregularity may be less innocent than has been suspected.

Experimental work by Rothberger and clinical observations of Scherf (personal communication) serve to throw even more doubt on the benign character of premature contractions. These investigators believe that extra-systoles precede and probably precipitate auricular fibrillation. It

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is certain that the extra-systoles produced by barium are frequently followed by ventricular fibrillation.

Perhaps of more importance than these theoretical considerations is the desirability of eliminating the very disagreeable symptoms so often associated with premature contractions. These vary from palpitation, precordial oppression, dyspnea and giddiness to actual attacks of syncope.

ETIOLOGY OF EXTRA-SYSTOLES

In man, premature contractions are usually idiopathic, but are often associated with heart disease with nicotine or caffeine excesses, following fatigue, gastro-intestinal or nervous disturbances.

Experimentally they may be aroused in various ways. They are produced by stimulation of the heart muscle by electric shocks, the application of small drops of acid or salts, and by large amounts of such systemic poisons as chloroform, digitalis, nicotine, adrenalin, or barium chloride.

Whatever their cause, it seems clear that quinidine, by prolonging the refractory period of the heart muscle, or by partially paralyzing the vagus, abolishes premature contractions. That the drug has this effect in animals has been shown by Lewis and his co-workers.[4]

RECOGNITION OF EXTRA-SYSTOLES

An extra-systole is a premature contraction of the auricles or ventricles and is manifested by intermission of an otherwise regular pulse, or by the occurrence of a small premature pulse wave.

The recognition of cardiac irregularity is, of course, a very simple procedure, but the identification of the character of the arrhythmia by ordinary clinical methods is by no means always easy. Even such a master of cardiology as Wenckebach occasionally feels the necessity of employing special methods, such as the electrocardiograph or polygraph, to differentiate fibrillation of the auricles from frequent premature contractions.

However, in the great majority of cases one can be reasonably certain of the diagnosis by the use of usual methods of physical examination. Granted that the pulse be irregular as the consequence of premature contractions, one can nearly always appreciate the prematurity of the extra beat by palpation or auscultation. This is especially easy since the premature contraction is always followed by a pause of unusual length, which in the case of ventricular extra-systoles is equal to two normal cycles and is called "compensatory". It must be remembered that if the premature beat occurs very early in diastole there is not sufficient blood in the heart to cause the aortic valves to open; a beat is then dropped at the wrist, the second sound is absent, as may be any cardiac murmurs which are audible with the dominant rhythm. In such cases by careful inspection of the veins of the neck the nature of the disturbance can usually be made quite obvious, as even when the ordinary "a", "c" and "v" waves cannot be clearly seen the extra beat frequently causes a sudden positive wave to appear in the jugular vein. This is due to the fact that ventricular extra-systoles generally occur at the time of the normal auricular systole, while auricular extra-systoles quite often occur at the end of ventricular systole. In either event the auricles and ventricles are in systole simultaneously, the right auricle consequently cannot empty itself and part of the blood is pumped back into the jugular veins.

It should be mentioned at this point that extra-systoles may occur regularly or irregularly, frequently or infrequently. Consequently a variety of arrhythmias may appear, ranging from coupled beats, the so-called bigemina, to the appearance of an extra-systole after each third, fourth, or fifth beat of the dominant rhythm. However, more commonly they are noted as isolated events causing intermission of the pulse.

With regard to differential diagnosis two arrhythmias are sometimes confused with extra-systolic irregularities; one is "slow" auricular fibrillation, the other partial heart block.

To differentiate frequent extra-systoles from auricular fibrillation is usually possible because exercise or the inhalation of amyl nitrite increases the irregularity of auricular fibrillation and tends to decrease the number of extra-systoles. It is to be remembered that extra-systoles are usually absent when the rate is over 120.

In heart block with dropped beats intermittence of the pulse occurs. However, as there are no heart sounds audible at the time of the missing pulse, this condition can be differentiated from an extra-systolic intermittence where the first heart sound is always present.

CLINICAL STUDIES

The clinical data relating to the quinidine treatment of extra-systoles is so scant that the published results can be summarized in a few words.

Wenckebach,[5] in 1914, apparently the first to advocate quinine therapy in this type of arrhythmia, concluded that the drug was of considerable value. Frey,[6] in 1918, discovered the more potent action of quinidine in cardiac irregularities. Smith[7] treated twenty patients affected by extra-systoles with quinidine; ten were cured and seven improved. Musser[8] secured good results in 60 per cent of his cases.

During the past few months approximately fifty patients with extra-systolic irregularities have been treated with quinidine in the Cincinnati General Hospital. After a preliminary dose of 2 grains of quinidine sulphate to exclude idiosyncrasy, doses of 2 to 5 grains three times a day have been given. Successful results, when obtained, usually occurred during the first 24 hours.

The results may be divided into two categories: the first, a relatively small group, consisted of patients without evidence of heart disease. In 85 per cent of these cases the extra-systoles were abolished, or reduced in frequency.

In the second group, patients with organic heart disease with extra-systoles, but without congestive failure, were treated.* In these patients it was rare to cause disappearance of the premature contractions. Usually their frequency was diminished.

It is only fair to state that the irregularities tended to reappear when the medication was discontinued.

White[9] has made an excellent summary of the dangers attendant on quinidine administration. He states: "Serious accidents can happen during quinidine therapy, but they are very rare and, in carefully selected cases (patients without congestive failure, long standing valvular or myocardial disease, or quinine idiosyncrasy), very unlikely. They include embolism due to pumping out by the heart of bits of intracardiac thrombus on restoration of normal auricular action. Sudden death without embolism has also been noted in several cases during quinidine therapy, and the cause has been variously explained by respiratory paralysis, cardiac paralysis, or other mechanism. Cardiac standstill is the most likely explanation, being due to the paralysis of both pacemakers of the heart in the sino-auricular and auriculo-ventricular nodes as the result of the toxic effect of the quinidine; when these nodes are depressed and the abnormal mechanism of auricular fibrillation is brought to an end by the drug, there may be no available pacemaker to take up the function of exciting the heart beat, death resulting".

The danger of embolism and of cardiac standstill at the time of reversion of a fibrillating heart to normal rhythm is of course not applicable to cases with extra-systolic irregularities. No untoward results have occurred in our series, and none is to be expected if properly selected cases are treated.

CONCLUSIONS

1. Quinidine sulphate is of great value in diminishing the frequency of, or abolishing, extra-systolic irregularities.

2. Its use should be restricted to patients without evidence of organic heart disease.

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* It is our opinion at present that the use of quinidine in such cases is inadvisable.

DISCUSSION

WM. H. BUNN, M.D., Youngstown—There is one practical matter that may be brought out in connection with the discussion of this paper: More patients come to my office because of premature contractions than any other heart condition. These patients are terribly worried. They feel their heart turning over or missing beats, and they are sure that it means serious heart disease. This condition often occurs in apprehensive people who really suffer mental torture, feeling that they are going to die or be forced to give up their work.

If one assures these patients that the condition is not due to organic heart disease, tries to remove the cause, whether it be nicotine, caffeine, gaseous distention of the bowels, or anxiety, a great service has been performed. It is only fair to say that some help can be given to stop this symptom, a mild sedative will often accomplish this. These patients should be told that the irregularity is likely to reappear, and one should make an effort to teach them to accept the condition and to put it in the background, so that they will not be annoyed by what is really almost always an unimportant disturbance of cardiac rhythm.

In recognition of the late Dr. J. C. M. Floyd's "untiring labor for the advancement of his profession", the Jefferson County Medical Society will present a portrait in oil of the late dean of Jefferson County's medical profession and former president of the Ohio State Medical Association to the Ohio Valley Hospital, Steubenville.

The portrait has been completed and will be presented in the near future at appropriate services. It is 24 by 30 inches in a gold leaf frame and was modeled from a picture taken of Dr. Floyd shortly before his death.

In deciding on the portrait as a tribute to Dr. Floyd, the society pointed out four reasons why the society should honor him, namely:

"He was senior physician of the society.

"He was a particularly useful man to the society through his untiring efforts in introducing and supporting legislation in the interest of the medical profession and public health.

"He was extremely faithful in his duties as a practicing physician over a period of half a century.

"His professional ethics were of the highest type."

General Medical Aspects of Endocrinology

With a Few Remarks Concerning Some of the Newer Hormones

E. P. MCCULLAGH, M.D., Cleveland, Ohio

THE following brief review of a few of the interesting features of hyper- and hypothyroidism, and hyper- and hypoparathyroidism is presented from a clinical standpoint.

Let us consider first some problems in the diagnosis of thyroid disorders.

Three conditions which commonly offer resistance to accurate diagnosis of thyroid disorders are (1) hyperthyroidism in remission, (2) neurocirculatory asthenia, and (3) hyperthyroidism masked as heart disease.

HYPERTHYROIDISM

In recent years, the indiscriminate use of iodin has increased tremendously the difficulty of accurate diagnosis of thyroid disorders. Patients with hyperthyroidism are frequently seen who have been taking Lugol's solution for several weeks, and at the time they present themselves for examination they may have very few symptoms or signs of hyperthyroidism remaining and the metabolism may be normal.

The essential factor in the diagnosis of hyperthyroidism in the case of such a remission is a painstaking history. Usually there is a characteristic onset of the condition with an increasing sense of stimulation, warmth, hyperhidrosis, forceful tachycardia, tremor, loss of weight in spite of a good appetite, and distinct improvement after taking iodin. Histories of patients with diabetes or tuberculosis may bear a superficial resemblance to those of patients with hyperthryoidism except for improvement on taking iodin in the case of the latter.

The most important finding from the physical examination is the general appearance of the patient. He is alert, he is apprehensive, the eyes have a brilliant stare, skin is flushed and perhaps a mild hostility may be noted. A similar appearance may be seen in hypertension and at times in beginning psychosis.

The general physical findings may be scanty. A goiter is usually present which may be solid, suggesting diffuse hyperplasia. Mild tachycardia may persist. There may be slight cardiac enlargement and usually the heart sounds have a peculiar loudness. The systolic blood pressure is often raised. Exophthalmos is usually absent in the early cases. Occasionally there is a residual tremor and the fine moist texture of the skin may be maintained.

In short, when the history is characteristic of hyperthyroidism, the appearance of the patient is suggestive, and the cardiovascular signs consistent, especially if improvement has been noted following the use of iodin, even though the basal metabolism is repeatedly normal, hyperthyroidism is still present. In such a case thyroidectomy should be performed.

NEUROCIRCULATORY ASTHENIA

Neurocirculatory asthenia is probably misdiagnosed hyperthyroidism more frequently than any other disease. The syndrome is seen usually in individuals under thirty years of age and is characterized chiefly by fatigue, nervousness and vasomotor disturbances.

It is easy to visualize the young woman of twenty whose general appearance as she sits in the consulting room suggests exhaustion. She complains that she is weak and nervous, that she has palpitation on the slightest exertion or even when at rest. She may have been losing weight. She believes a goiter is responsible for these symptoms.

It is often stated that in such a patient nervousness, tachycardia, tremor, hyperhidrosis, weight loss, and goiter are present and indeed the basal metabolism (especially the first estimation) may be elevated. From such a simple statement of facts the conclusion often is arrived at that such a patient has hyperthyroidism. The symptoms and signs, however, must be more critically considered.

The nervousness has probably been present for a long period with slight change, and the appearance of the patient is suggestive of exhaustion. The tachycardia is extremely variable and may change markedly on deep breathing, on ocular pressure, on forceful flexure of the trunk (the so-called Erben's phenomenon) or even on forceful convergence of the eyes. (Ruggeri's sign). Tremor is usually coarse.

Hyperhidrosis is present chiefly in the extremities and is associated with coldness. Loss of weight is usually associated with a poor appetite. Goiter, if present, is commonly of the diffuse, soft, so-called colloid type.

In cases of neurocirculatory asthenia the pupils are frequently dilated and may show hippus or positive visero-ocular reflex.

The impressive points in such a case are (1) the prominence of fatigue in the clinical picture, (2) the variability of the pulse rate, and (3) the coldness of the extremities. In such patients even though several metabolism tests may show a rate of plus 16 or plus 20 per cent no hyperthyroidism is present and I know of no type of patient to whom thyroidectomy may do more damage. It is

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true that in nearly all cases repeated metabolism tests may show a rate falling to normal but this may occur also in mild hyperthyroidism if the patient is at rest.

HYPERTHYROIDISM MASKED AS HEART DISEASE

Hyperthyroidism is often misdiagnosed heart disease and patients frequently go about for years with a diagnosis of rheumatic or arteriosclerotic heart disease, with auricular fibrillation or myocardial degeneration, because in cases of mild hyperthyroidism of long standing the cardiac symptoms and signs frequently overshadow all others until they are lost sight of.

In all cases of auricular fibrillation the possibility of the presence of a goiter should be borne in mind as a cause, and in all cases of myocardial damage in which a goiter is present, the existence of the goiter should never be dismissed lightly as a possible cause of such damage, although other signs of hyperthyroidism may not be evident. The so-called "goiter heart" is enlarged to the left, there is increased force and amplitude to the apex beat and the sounds are peculiarly loud. Usually a systolic, non-transmitted, apical murmur is present and perhaps a systolic murmur may be heard at the base. Sometimes a systolic vibration may be felt. A diastolic thrill or murmur is never present. Tachycardia and elevation of the systolic blood pressure may or may not be present.

The history is often suggestive of hyperthyroidism but this may be indefinite. There is no history of rheumatism. Here again the general appearance of stimulation, staring and alertness is important. A goiter is usually present and if the condition is suspected and the basal metabolism is persistently elevated the diagnosis is easy. Not infrequently, however, the basal metabolic rate may be normal in such cases at the time of observation. Such patients are greatly improved by thyroidectomy.

HYPOTHYROIDISM

Let me remind you that hypothyroidism is not necessarily present in all cases in which a low metabolic rate is present. Hypometabolism may occur in chronic exhaustion from various causes, in arthritis, in pituitary disorders, etc.

The results of treatment for this condition would seem to indicate that the diagnosis should be made by a careful correlation of symptoms, signs and metabolic studies.

Hypothyroidism is of especial interest to ophthalmologists, because it is so often associated with ocular muscle imbalance.

Hypothyroidism can seldom be diagnosed by the appearance of the patient. The patient usually complains of lack of energy and endurance, or as he terms it "lack of pep." He may have noted nervousness, coldness, diminished mental alertness and drowsiness or some loss of memory.

Careful questioning may be necessary to reveal further facts. The patient may have noted dryness of the skin and hair, brittleness of the nails, or slight edema especially about the eyes. Paresthesia in hands and feet is frequently noted.

In 100 non-operative cases analyzed recently there was a gain in weight in only 43 per cent, bradycardia in only 39 per cent and a temperature below 98 in 26 per cent.

In the presence of typical symptoms of hypothyroidism a diagnosis may be established although the metabolic rate is not below minus 10. On the other hand, the metabolism may be as low as minus 30 and no hypothyroidism be present. A basal metabolic rate of less than minus 25 per cent, however, is probably due to either thyroid or pituitary disease. In cases in which the diagnosis is questionable a thorough trial of thyroid feeding may be useful. The average dose is 2 grains of dessicated thyroid or 10 grains of the whole gland per day.

Four interesting and common laboratory findings in the presence of hypothyroidism are given below:

(1) Carbohydrate tolerance may be so increased that to produce alimentary glycosuria is practically impossible. Increased tolerance was found in 45 per cent of 20 cases in this series.

(2) Low gastric acidity is often present. Hydrochloric acid was absent one hour after an Ewald test meal in 16 cases of a total of 45, i.e., 35 per cent.

(3) Lymphocytosis of 40 per cent or over occurs in about 30 per cent of cases.

(4) Electrocardiogram showed low amplitude with flat T waves in 16 cases in 58 or 27 per cent. This does not seem to be caused by previous myocardial damage since the amplitude may be made normal on administration of thyroid extract.

CHRONIC POSTOPERATIVE TETANY

In connection with hypoparathyroidism let us consider only chronic postoperative tetany which is due to the removal or destruction of the majority of the parathyroids. The occurrence of this condition may be unavoidable even when standard operative technique is used.

Chronic tetany is characterized by a decrease in serum calcium, a retention of phosphates, intermittent attacks of muscle spasm, and in some cases trophic changes.

The serum calcium is reduced from a normal content of 10 mgr. per 100 c.c. to below 9 mgr. In some chronic cases the serum calcium has been known to fall to 5.3 mgr. per 100 c.c. in the presence of very slight symptoms of tetany. The phosphates rise from a high normal of 4.5 mgr. per 100 c.c. to 5 or above.

In many cases the symptoms are for the most part latent; mild paresthesia of hands or feet may be present but may go unmentioned for years.

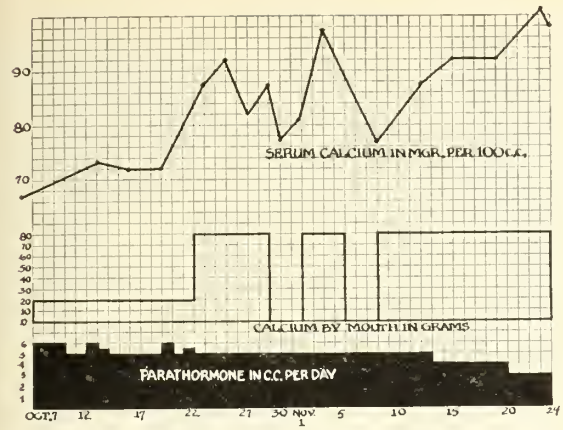


Fig. 1. Photograph showing deformity caused by multiple lesions. The presence of tumors in the left ilium and left maxilla is obvious. Marked deformity of the spine is noticeable and a large tumor is present in the right scapula.

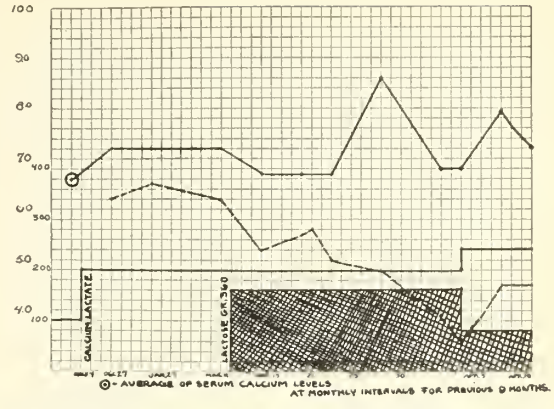


Fig. 2. Roentgenogram of the pelvis showing the distribution of the lesions present. Areas of rarefaction and cyst formation are seen, especially in the left pubis and ischium, and the left femur and ilium.

Author's Note—In Chart I "Calcium by mouth in grams" should read "Calcium by mouth in *grains*."

In other cases more pronounced symptoms appear at the menses, during infection or in exhaustion. In the latent stage Chvostek's sign is usually present. No case has been seen in which Trousseau's and Erb's signs were not present.

An acute attack of tetany is usually preceded by paresthesia in hands or feet; fibrillary twitching and ciliary spasm may occur, then carpo-pedal spasm, hypersensitiveness is present in the extremities; there is spasm of the facial muscles with circumoral pallor; hyperpnoea, laryngeal spasm with stridor, and abdominal pain are noted, and in extreme cases all muscles may be involved. Obviously, motor, sensory, and sympathetic nerves are all involved.

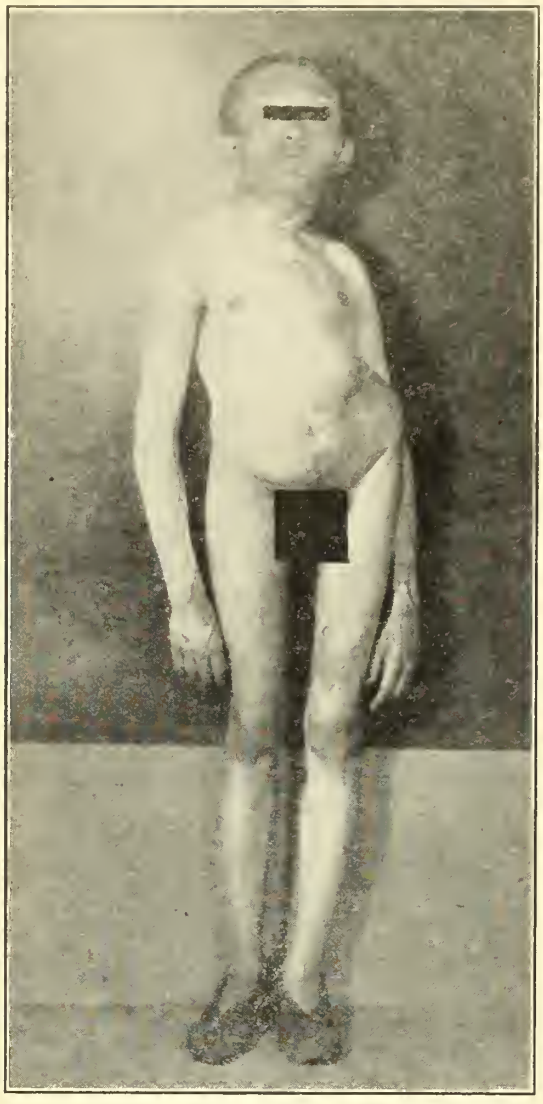
In some cases tetany may occur with extreme suddenness, producing generalized convulsions, usually tonic, but nevertheless frequently mistaken for grand mal. In other cases muscle spasm increases so slowly that walking is interfered with and Parkinson's disease may be closely simulated. Temporary psychoses may occur. The general nutrition of the tissues is poor, the color often sallow, the teeth may be loose, the nails may become chalky white and fall out, and diffuse lenticular haziness may progress to cataract.

The most important reason for thorough treatment of chronic tetany is the prevention of cataract. The patients become so tolerant of low calcium that symptoms are no guide and blood studies must be used.

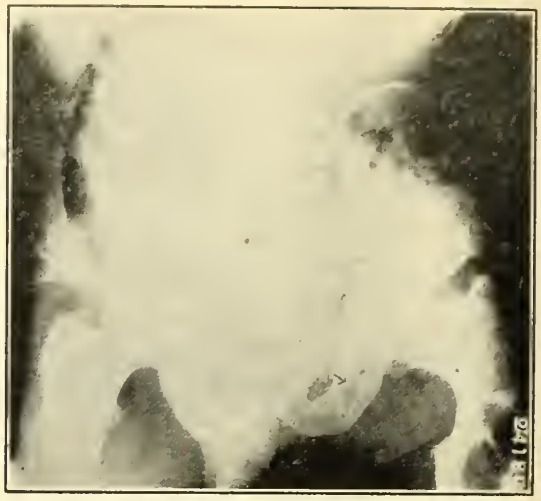
The most important factor in the treatment of chronic tetany is the giving of large enough doses of calcium. Calcium lactate powder in doses as large as two heaping teaspoonfuls three to four times per day is usually sufficient. If this amount produces diarrhea, calcium carbonate may be substituted. If calcium alone is not sufficient, lactose in doses of one or two teaspoonfuls three or four times a day should be added, which will help to lower the blood phosphates. If this amount produces diarrhoea the dose should be lessened. Milk is useful as it contains both calcium and lactose. Ultra-violet light is helpful. The usual doses of viosterol are of doubtful value. Parathormone may be necessary rarely. In acute cases 5 to 10 c.c. of a 5 or 10 per cent solution of calcium chloride may be necessary. It is best given by the gravity method preceded and followed by saline. Parathyroid administered by mouth has been practically useless in my cases.

Chart I represents a case of chronic parathyroid tetany and illustrates the value of large doses of calcium by mouth. The upper line represents the total serum calcium which varies from below 7 mg. per 100 c.c. to above 10 mg. per 100 c.c. The lines in the middle of the chart represent the dose of calcium lactate in grains by mouth per day. The lower portion of the chart which is blocked represents the amount of parathormone in c.c. per day. At first the patient was receiving 20 grains of calcium per day and 5 and 6 c.c. of parathormone. The blood calcium varied about 7 mg. per 100 c.c. On October 22nd the parathormone dosage was not changed but the dose of calcium was increased to 80 grains per day. A marked increase in serum calcium followed. When the dose of calcium was decreased the serum calcium fell but rose again when the calcium was increased to the same dose on November 1st. When it was discontinued, on the 5th day of November the serum calcium again fell but after November 19th it continued to rise following the administration of calcium even though the parathormone was lessened. Subsequently this patient's symptoms were completely relieved by doses of calcium lactate amounting to between 200 and 250 grains per day without the administration of any parathormone.

Chart II represents another case of chronic parathyroid tetany and illustrates the value of lactose in the case of patients in whom the admin-



istration of large doses of calcium lactate alone is not sufficient to control the symptoms of tetany. The upper line represents serum calcium in mgr. per 100 c.c. The interrupted line represents the inorganic phosphate of the whole blood in mgr. per 100 c.c. The straight black line represents the amount of calcium lactate given by mouth in grains per day and the cross-hatching represents the amount of lactose given by mouth per day. The upper line represents serum calcium; the circle represents the average serum calcium over a nine months period. The patient was receiving 100 grains of calcium lactate by mouth per day. Between November 12th and March 11th she was taking 200 grains of calcium lactate by mouth per day. During this time the blood phosphates were measured and are reported in the chart. On March 11th in addition to the previous medication lactose powder was given in doses of 120 grains three times a day. It will be noted that the blood phosphates fell following the administration of lactose. During this time the patient's condition very materially improved. The blood calcium was not raised except in the case of the one peak which is unexplained. On April 3rd the dose of lactose was lessened to 180 grains per day and the blood phosphates rose somewhat although they were still within normal limits.



HYPERPARATHYROIDISM

Hyperparathyroidism is a syndrome which is characterized by an increase in serum calcium, a decrease in inorganic phosphates, muscular atonia, general decalcification of bones, and multiple bone lesions. The bone lesions are identical with those known as osteitis fibrosa cystica of the generalized type. There is also diffuse rarefaction affecting all the bones.

The first cases of this type to be reported were all associated with tumor of the parathyroids but more recently cases have appeared in which there is apparently functional overactivity. Usually the serum calcium in such cases is well above 12 mgr. and the blood phosphates below 2 mgr. per 100 c.c. In cases of long standing this is apparently not always true. This is to be expected since experimental evidence shows that one large dose of parathyroid extract may produce a marked hypercalcemia but if repeated doses are used the calcium may gradually fall to within normal range and the bones become decalcified.

CASE REPORT

A man 31 years of age came to the Clinic with a history of bone lesions which had been known to be present since he was 13 years of age. These lesions involved the skull, vertebrae, sternum, ribs, pelvis and long bones. They were painful and caused much loss of sleep. Fractures were frequent. The serum calcium was above 12 mgr. Blood phosphates totaled about 2 mgr. *X*-ray examination of the bones showed the presence of typical osteitis fibrosa cystica. The calcium balance was negative and the blood phosphatase, which is the recently discovered enzyme in the blood which has to do with bone formation and

destruction,[1] was increased to ten times the normal.

Parathyroidectomy was performed and one hypertrophied gland removed. The calcium dropped to normal, blood phosphates rose, phosphatase was decreased to one-third of its original value, the pain in the bones disappeared, strength increased, and no fractures have occurred in a year.

SOME OF THE NEWER HORMONES

Time will not permit us to consider the pituitary gland but let me remind you of a few facts in connection with some of the more recently discovered hormones. The Aschheim-Zondek[2] test for pregnancy is an important recent advance. As you know, not only an ovarian but also a pituitary hormone appears in the urine in pregnancy. Due to the presence of pituitary hormone, injection of such urine into young test mice produces changes in their ovaries within 100 hours or less which allow of the diagnosis of pregnancy. The result of this test is accurate in at least 98 per cent of cases—more accurate than the Wassermann reaction and probably the most dependable biological test. In the Friedman[3] test similar changes are seen in the ovaries of rabbits after intravenous injection of pregnancy urine. The Mazer-Hoffman[4] test for pregnancy depends on the fact that pregnancy urine, due to the presence of theelin, produces oestrus when injected into castrated female mice.

Folliculin, the follicular hormone of Allen and Doisy,[5,6,7] is on the market under the names of amniotin, estrogen and theelin. Folliculin occurs in urine, amniotic fluid and blood in pregnancy and will produce oestrus changes in castrated animals. Its clinical value is not yet known.

Cortin, so named by Hartman,[8] is the active principle of the adrenal cortex. It has recently been described by Swingle and Pfiffner.[9] Its potency is proved by the fact that it keeps adrenalectomized cats alive for an indefinite period or will bring them from coma to normalcy. Its activity clinically in Addison's disease has been confirmed by Rowntree[10] and others. Recently Roy McCullagh[11] has produced this material in the laboratories of the Cleveland Clinic. It was found to be potent experimentally and in one case in which I tested its action clinically it appeared active although the results obtained were not as striking as those reported by Rowntree.[10]

The male sex hormone may be produced from testes by the method used by Koch and Gallagher.[12] Funk and Harrow[13] have described a method for obtaining it from the urine of young men and animals. Roy McCullagh could not corroborate the work of Funk and Harrow, but working with a different method he found this substance to be present. The hormone is tested on capons. As is well known, the combs and wattles of castrated young roosters shrink to a very small size. Injection of the male sex hormone in such birds causes these shrunken appendages to grow rapidly. At present we are making a test of the material but are not prepared to make any statements as to its clinical value.

The luteinizing hormone[2] of the anterior lobe of the pituitary gland may also be obtained from the urine. This substance causes the formation of corpora lutea in the ovary and is apparently active clinically. It lessens menstrual bleeding and evidence is quickly accumulating which indicates that this may be the means of a physiological control of menorrhagia.

Emmenin has recently been described by Collip[14] who believes it originates in the placenta. It is apparently active when given by mouth and causes stimulation of sexual development. Its origin is still debated as it has several properties suggesting its possible origin in the pituitary. Attempts are being made at present to determine its clinical application.

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Dr. C. H. Creed, head of the state bureau of examination and classification of the State Department of Public Welfare, has been appointed superintendent of the Athens State Hospital, succeeding the late Dr. John H. Berry. Dr. Creed was for 11 years assistant superintendent of the Columbus State Hospital and previous to that had been connected with the State Hospital for Epileptics, Gallipolis.

Whooping Cough ≠≠≠ Pertussis

FINLEY VAN ORSDALL, M.D., Columbus, Ohio

"Whooping cough is a specific infectious disease characterized by a paroxysmal or spasmodic cough usually ending in a long sonorous inspiration and often accompanied by vomiting." (Forcheheimer).

There is no other communicable disease so dangerous to the very young; there is no other disease causing an equal amount of suffering of which parents show such an unaccountable disregard, not only for the safety of their own little ones, but also for the lives of their neighbors' children.

Whooping cough is endemic in most cities, and epidemics of more or less severity are so frequent that they rarely attract much more than local attention.

HISTORY

The first epidemic of which we have record occurred in Paris in 1578 and was described by du Baillou. Thomas Willis wrote of whooping cough occurring in England in 1658, and Sydenham fully described the symptoms in 1679.

During the eighteenth and nineteenth centuries epidemics frequently occurred, scattered over the remainder of the civilized world; the last countries to be invaded being New Zealand in 1847, and Australia in 1890.

ETIOLOGY

A bacillus first described in 1906 by the French observers Bordet and Gengou is generally accepted as the causative agent of whooping cough. This organism is known as *Bacillus pertussis* or *B. Bordet-Gengou.*

It may be found in great numbers in the sputum expelled from the depths of the respiratory tract by coughing during the catarrhal and early paroxysmal stages.

Morphologically *B. pertussis* closely resembles the influenza bacillus.

SUSCEPTIBILITY

With the single exception of measles, there is no other infection to which there is such almost universal susceptibility in infancy and childhood, and whooping cough is the more dangerous because there is no natural immunity against this disease during the first six months of life as there is against measles, and it is just at this age, "when the flame of life flickers feeblest" and during the second six months of helpless infancy, that whooping cough strikes its hardest blow, over 50 per cent of the deaths occurring among children under one year of age.

No age is wholly exempt; cases have been recorded in individuals beyond the eightieth year of life.

As a rule one attack protects against subsequent infection. This does not always hold true; a second attack *may* occur but is usually mild and its symptoms may be so moderated or modified as to disguise the nature of the case and so be unrecognized.

TRANSMISSION

Generally by direct contact with the secretions of the mouth or nose, and only a very short exposure is required to contract the infection. Handkerchiefs, drinking cups, toys, etc., also act as vectors. During epidemics, cats and dogs have been observed to have coughs of a paroxysmal nature, supposed to be a modified whooping cough and so transmissible to children.

In every epidemic there are many missed cases, the so-called abortive type, in which the disease only reaches the catarrhal stage without developing anything actually characteristic, and, as the infection is communicable from the appearance of the first symptoms, and is most contagious at this early stage when the nature of the affection can only be suspected. These cases account for much of the difficulty in checking its spread.

The disease may also be transmitted in its last stage and during convalescence. (Rosenau).

INCUBATION

The incubation period is commonly seven days, following which is a *prodromal period,* or period of invasion, lasting a few days during which there is often simply lassitude, some headache and disturbed sleep. Then follows the *first or catarrhal stage* which lasts from seven to ten days.

A slight fever, a coryza and a cough make their appearance so gradually and insiduously that a diagnosis is practically impossible unless a history of exposure is obtained.

Soon, however, the cough, increasing in frequency becomes the predominant symptom; it becomes spasmodic and choking, especially at night, and the *second or paroxysmal stage* is reached. This has a duration of from four to six weeks. There can be no failure in diagnosis now; the one characteristic and unmistakable symptom of the disease, the "whoop", occurs. This is caused by a desperate inspiratory effort to fill the lungs, deflated by incessant coughing, through the narrowed glottis, and is a very distressing thing to witness.

Older children fearfully realize an impending attack and desperately seek aid of their helpless parents; in infants attacks may cause convulsions or an asphyxia sufficiently severe to necessitate

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artificial respiration; adults describe an attack as a horrible sensation of suffocation.

The paroxysm begins with a short pause in breathing accompanied by choking movements quickly followed by a deep inspiration and then a series of rapidly repeated coughs which convulse the entire body. The face and mucus membranes become almost purple, the eyes water and seem to protrude, then comes the distressful inspiration, the "whoop".

These paroxysms increase in frequency and severity during the first two weeks of this stage and remain severe for about one week during which there may be as many as 50 or 60 attacks in 24 hours.

Each attack is usually accompanied by choking and vomiting, by profuse perspiration and often by epistaxis, then, after a variable number of such spasms, a small amount of tenacious, glairy mucus is expelled and the attack ceases.

Usually there is slight or no fever and between paroxysms the child may evince a deceptive liveliness, an appearance of well-being that his puffy face and worried look contradict as a sign that he is actually improving.

Attacks may be brought on by anger or fright, by over-eating, by sneezing, by too violent exercise or even by a sudden blast of air.

There is no definite ushering-in of the *third stage* or *stage of decline*, which generally has a duration of two or three weeks.

The attacks become less frequent, the whoop finally disappears and the disease resembles an ordinary bronchitis.

Occasionally a cough may persist for months and complications are most common and most severe in this stage. A rise in temperature is always a suspicious sign of these complications.

COMPLICATIONS

1. *Hemorrhage.* The strain of the severe and prolonged coughing often causes nose-bleed and extravasation of blood beneath the conjunctiva or an intra-cranial vessel may be ruptured giving rise to paralysis.

2. *Respiratory system.* Bronchitis or bronchopneumonia are not uncommon and occasionally a pneumothorax develops.

3. *Digestive system.* Vomiting interferes with proper nutrition and the child's vitality is greatly lowered. Frequently, especially in the summer months, a diarrhea also contributes to a lowering of vitality. Protrusion of the tongue during the attacks of coughing often produces a stubborn and painful ulcer of the frenum.

4. *Nervous system.* Not rarely convulsions occur or a meningitis or an encephalitis may develop.

PROGNOSIS

Whooping cough usually runs a favorable course in healthy children over five years of age and is rarely fatal after puberty. The younger the child, the more dangerous the disease; over 50 per cent of all deaths from whooping cough occur in children under one year of age and many deaths recorded as due to bronchitis and bronchopneumonia are secondary to pertussis.

WHOOPING COUGH IN OHIO

More little children die in Ohio of whooping cough each year than of any other communicable disease.

Few parents are careless enough or ignorant enough to expose their children to a known case of whooping cough but very many parents do not seem to realize that several infectious diseases begin with symptoms of a common cold or that every cold has dangerous possibilities to an infant.

Whooping cough is not only highly infectious but is one of the diseases *most* infectious just at the stage when it seems to be nothing more than an ordinary cold.

The following table shows that it was much more dangerous to young children during 1930 than any one of the diseases of childhood that parents have always especially feared.

TABLE No. 1

DEATHS IN OHIO—1930

	Deaths, all ages	Deaths, under 5 years	% under 5 years
Whooping cough	204	186	91
Measles	181	127	70
Scarlet Fever	173	61	35
Diphtheria	160	87	54
Epidemic meningitis	131	42	32
Poliomyelitis (Infantile paralysis)	112	38	34

The following table shows that this excess in the number of little children dying annually of whooping cough continues year after year. This

TABLE No. 2

DEATHS UNDER 5 YEARS OF AGE—1921-1930

	1921	1922	1923	1924	1925	1926	1927	1928	1929	1930	Total
Whooping Cough	472	276	474	446	356	621	258	242	499	186	3,830
Measles	123	201	426	118	59	609	26	142	178	127	2,009
Scarlet Fever	208	97	152	102	93	79	57	46	55	61	950
Diphtheria	498	437	310	191	184	254	256	197	112	87	2,526
Epid. Meningitis	54	29	61	30	51	33	45	40	63	42	448
Poliomyelitis (Infantile Paralysis)	82	24	32	39	65	45	166	27	18	38	536

is not a pleasant thing to think about when we know that by simply using precaution and intelligence very few of these little ones need have died.

"It is impossible to state with any accuracy the case fatality rate since whooping cough is the most poorly reported lethal communicable disease of childhood. One reason for this poor reporting is probably that relatively few cases are seen by physicians, or, if seen, it is seen during the catarrhal stage and a diagnosis is not made. After the "whoop" begins many mothers, and practically all grandmothers, consider themselves quite as competent as a physician to deal with the situation". (Godfrey).

This opinion has undoubtedly caused the death of many thousands of little children.

There have been 100,336 reported cases of whooping cough in Ohio during the past ten years. Measles, with 265,347 reported cases and scarlet fever with 135,806, while exceeding whooping cough in the number of cases, do not approach it in the number of deaths during the ten year period; there were 2,665 deaths from measles, 2,296 from scarlet fever and 4,018 from whooping cough.

TABLE No. 3

WHOOPING COUGH CASES AND DEATHS 1921-1930 WITH RATES PER 100,000 POPULATION

	1921	1922	1923	1924	1925	1926	1927	1928	1929	1930
Cases	8452	8430	9,203	10,608	8975	15,186	7478	9236	15,884	6884
Case Rate	142.9	140.2	150.4	170.6	142.0	236.4	114.6	139.3	236.0	103.5
Deaths	504	294	500	462	364	650	270	249	521	204
Death Rate	8.52	4.88	8.17	7.42	5.75	10.11	4.13	3.75	7.74	3.05

In the past decade there have been only 45 deaths from whooping cough reported in persons over 10 years of age; this is 1.1 per cent of the total number of deaths for the ten year period. Over 95 per cent were in children under five and 55 per cent were in infants under one year of age.

There can be no doubt of the necessity of protecting the very young from the infection, and Table No. 4 definitely shows that the longer a child can be guarded from the almost inevitable eventful attack, the better its chance of survival.

TABLE No. 4

WHOOPING COUGH DEATHS UNDER 5 YEARS—1921 TO 1930

	1921	1922	1923	1924	1925	1926	1927	1928	1929	1930
Under 1 year	280	157	262	273	211	349	163	128	287	126
1 year	112	74	133	111	100	158	51	71	126	41
2 years	45	29	49	41	25	66	25	23	44	10
3 years	23	12	18	11	14	33	12	14	24	5
4 years	12	4	12	10	6	15	7	6	18	4

Because of some unknown reason 54.9 per cent of all deaths from this disease are among females and only 45.1 per cent among males.

Table No. 5 shows that more deaths occur in Ohio in early Spring than during any other season.

TABLE No. 5

WHOOPING COUGH DEATHS BY MONTHS—1921-1930

	1921	1922	1923	1924	1925	1926	1927	1928	1929	1930	Total
January	55	19	43	33	20	46	23	6	70	19	334
February	74	30	70	41	20	48	27	14	45	29	398
March	64	43	87	76	31	87	34	10	62	16	510
April	58	28	45	69	28	109	31	20	47	28	463
May	46	31	42	52	36	84	20	38	50	22	421
June	54	22	36	42	29	60	35	14	60	17	369
July	36	23	38	46	46	49	30	11	48	14	341
August	50	18	26	33	39	53	20	27	49	20	335
September	28	20	23	20	44	34	22	24	36	12	263
October	11	17	30	14	26	20	12	13	24	10	177
November	16	19	21	16	15	34	10	22	12	9	172
December	12	24	29	20	30	25	6	50	18	8	222
	504	294	510	462	364	650	270	249	521	204	

Table No. 6 shows the average whooping cough death rate per 100,000 population for the ten years 1921-1930, in the general health districts of Ohio, ranked according to decreasing rates.

TABLE No. 6

Scioto County	21.71	Preble County	6.03
Hocking County	14.77	Clermont County	5.98
Clark County	13.02	Fulton County	5.97
Lawrence County	12.93	Licking County	5.95
Ross County	12.70	Champaign County	5.73
Athens County	12.65	Miami County	5.69
Cuyahoga County	12.62	Clinton County	5.63
Pike County	11.32	Allen County	5.55
Trumbull County	11.08	Morgan County	5.49
Greene County	11.00	Knox County	5.40
Marion County	10.62	Paulding County	5.33
Vinton County (no district)	10.39	Holmes County	5.31
		Fairfield County	5.07
Hamilton County	10.34	Sandusky County	5.05
Lake County	9.85	Ashtabula County	5.04
Hardin County	9.80	Putnam County	5.04
Jackson County	9.65	Summit County	4.99
Noble County	9.52	Brown County	4.91
Mahoning County	9.49	Van Wert County	4.78
Belmont County	9.07	Lorain County	4.74
Adams County	9.06	Hancock County	4.69
Butler County	9.01	Shelby County	4.68
Fayette County	8.94	Geauga County	4.58
Perry County	8.80	Monroe County	4.47
Meigs County	8.74	Williams County	4.46
Gallia County	8.70	Medina County	4.40
Columbiana County	8.69	Union County	4.31
Pickaway County	8.50	Henry County	4.29
Jefferson County	8.49	Erie County	4.10
Franklin County	8.17	Wyandot County	4.10
Stark County	8.15	Ottawa County	4.05
Madison County	8.14	Morrow County	3.84
Guernsey County	8.01	Darke County	3.67
Warren County	7.58	Delaware County	3.48
Tuscarawas County	7.48	Logan County	3.40
Montgomery County	7.28	Ashland County	3.25
Harrison County	7.07	Wayne County	3.21
Auglaize County	7.05	Seneca County	3.18
Muskingum County	6.88	Carroll County	3.13
Huron County	6.72	Wood County	3.11
Coshocton County	6.49	Portage County	3.07
Lucas County	6.41	Richland County	2.79
Mercer County	6.32	Defiance County	2.55
Washington County	6.12	Highland County	2.53
		Crawford County	1.65

Table No. 7 shows the average whooping cough death rate per 100,000 population for the ten years 1921-1930, in ten cities of Ohio, ranked according to decreasing rates.

Hamilton	9.85	Springfield	5.88
Cincinnati	9.41	Dayton	5.32
Canton	7.34	Cleveland	5.29
Youngstown	7.14	Columbus	4.68
Akron	5.88	Toledo	3.74

CONCLUSION

Whooping cough kills more little children than any other communicable disease.

It is the most infectious of all the diseases of childhood except measles.

Whooping cough is most readily transmitted in its early stages when it resembles a common cold, and a positive diagnosis is practically impossible. In older children and adults there may be no whoop during the course of the disease. This is always the case in very young infants.

Until parents have learned how dangerous a "cold" may be to their little children, whooping cough and several other communicable diseases will continue to reap their harvest.

If your child develops a cold do not give it home remedies, consult your physician. If older members of the family have colds, keep them away from the baby.

If there is whooping cough in your community, keep other children away from your little children, and keep your children at home.

If you have neglected to call your physician early and your child develops whooping cough, or if you even suspect the disease, call him. He may be able not only to save your child's life, but by informing the health department, save the lives of other children.

The Ohio Sanitary Code requires:

For the patient: Isolation of the patient for a period of at least two weeks from the development of the characteristic cough. Such isolation shall be construed to imply confinement to the house, rooms or apartment, except that the patient may be permitted to go into his own yard or into the streets when under the observation of a responsible person.

For exposed persons: (1) Residing in the house or place with the patient. Quarantine of susceptible children until fourteen days from the release of the patient. (2) Residing apart from the patient. Quarantine of susceptible children for a period of fourteen days from the time of last exposure to the disease. Provided that when the date of first exposure is accurately known or can be definitely determined, susceptible children shall be quarantined only from the seventh to the fourteenth day following such exposure.

Disinfection: Concurrent disinfection of the discharge from the nose and throat of the patient and of all articles soiled with such discharge. Cleansing of the sick-room when the patient is released.

Annual convention of the Association of Dairy, Food and Drug Officers of the United States will be held in Cincinnati next September. Dr. W. H. Peters, Cincinnati health commissioner, and S. A. Postle, chief of the Cincinnati bureau of the Food and Drug Administration, U. S. Department of Agriculture, are in charge of arrangements for the meeting which probably will be attended by approximately 200 delegates.

Fifth Annual Session of the All-Ohio Safety Congress will be held in Columbus, April 19, 20, and 21, according to an announcement of Wellington T. Leonard, chairman of the State Industrial Commission. All sessions of the congress and the exhibits will be at the Neil House. Arrangements for the meeting are being made by the Division of Safety and Hygiene, State Department of Industrial Relations.

A chapter of Sigma Xi, national scientific honorary fraternity, has been installed at Western Reserve University.

The Clinical Examination of the Autonomic Nervous System

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PROGRESS in clinical medicine depends upon the accuracy of observations and the verity of the interpretation of those observations. If the physiological principle used to explain a symptom is unsound, the symptom is no less true than the theory to explain its cause is false. The clinician has constantly to change his conception of physiology to meet the requirements of advancing knowledge.

The pioneer work on the autonomic nervous system by Gaskell and Langley in England stimulated investigators all over the world and has led to a tremendous increase in the knowledge of the anatomy and physiology of the autonomic nervous system. The clinician has not made use of much of that knowledge but rather has, to use the words of Andre-Thomas, taken the sympathetic system to replace hysteria as a medical waste basket.

In this paper, the terminology of Langley[1] is used, and one speaks of this portion of the nervous system as the autonomic nervous system, which is divided in turn, into the sympathetic and the parasympathetic divisions. In general these two divisions physiologically act antagonistically.

This physiological antagonism led Eppinger and Hess[2] in 1909 to formulate their clinical theory of vagotonia and sympatheticotonia. This interesting concept aroused great clinical interest and led to the hope that perhaps good sound physiology would eventually explain the symptoms of the capricious neurotic, a hope we still cherish. However, the clear-cut syndromes they describe are found in textbooks and not in the clinic. It is unfortunate that their terminology is still so widely used. That a patient may have a rapid pulse, dilated pupils, and cold, sweaty hands which are produced by sympathetic stimulation, and at the same time have gastric hyperacidity and hypermotility of the intestinal tract which is associated with parasympathetic (vagus) stimulation, is common knowledge. Such observations led to a concept of a dysbalance or an imbalance of the autonomic system. How the future will explain this perverted physiology remains to be seen. For the present we will have to accept the patient as we find him and call the case one of "vegetative diathesis" or "autonomic imbalance" for want of a better term.

A clinical evaluation of the autonomic nervous system is not easy. There are a number of factors that alter the reactions and lead to erroneous conclusions.

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One of the most important factors that has not been stressed by many investigators, is the physique or bodily constitution of the patient. Kretschmer[3] divides the human biotypes into the asthenic, athletic, and pyknic builds. A fourth type resulting from endocrine disturbances he calls the dysplastic type. In general, these types can be recognized by ordinary observation. They can be classified more accurately by actual measurement. Wertheimer's index[4] is a rapid and simple method. It must be remembered that the bodily build changes with age and consequent growth. The child at puberty shows increased growth of the long bones which makes the asthenic habitus predominate. Later in life, the tendency is to take on weight and the pyknotic habitus. The index values given by Wertheimer were determined on adults around thirty years of age. Most of the adolescents measured by the writer are of either asthenic or athletic build, but it is fairly certain some of them will become pyknotic later in life. Pende[5] of the Italian school has studied the vegetative equipment of these constitutional types. The pyknic type, which Viola showed had relatively large visceral organs, (megalosplanchnic), has, according to Pende, a rich vegetative and emotional development, and is, therefore, called by him hypervegetative. That this type of patient is extraverted, emotionally active, viscerally calm, but subject to great fluctuations in mood, is obvious. The asthenic type on the other hand, has relatively under-developed visveral organs (microsplanchnic) and is called by Pende hypovegetative. This type of patient is in general of the introverted, emotionally lame, viscerally irritable type, subject to what we call the vegetative diatheses, the asthenic psychoneuroses, and to dissociation between consciousness and mood, better known as schizophrenia. In general the hypervegetative type reacts excessively to sympathetic stimulation by adrenalin, whereas the hypovegetative type shows very little reaction to adrenalin, particularly in reference to changes in systolic blood pressure.

Another factor to be considered in evaluating responses of the autonomic nervous system is the condition of the glands of internal secretion. Hyperthyroidism stimulates the irritability of the sympathetic system. This can be shown by the excessive reaction of the sympathetic nerves to stimulation by adrenalin. That is the basis of the Goetsch test. In myxedema the effect of adrenalin is slight. A close relationship between the pituitary gland and the vegetative centers in the tuber cinereum and hypothalamus is known to exist, but the changes that disease of the

pituitary body or the diencephalic centers may produce in the responses to tests of the autonomic nervous system, have not been clinically defined.

A study of the patient's metabolism is necessary if there is a doubtful hyperthyroidism or other endocrinopathy. A vegetative diathesis is often confused with hyperthyroidism because of similarities in the clinical picture. A persistently increased basal metabolic rate is not characteristic of a disturbance of the autonomic system. The sympathetic system is excito-catabolic, and in states of emotion catabolism increases and there is widespread vasoconstrictor effects and glandular changes. On the other hand, the parasympathetic system regulates anabolic functions. The sympathetic system according to Cannon[5] protects the human cytoplasmic matrix from disturbing impacts from the outside, serving an important emergency function. It plays a role in metabolism and the economy of the individual.

In anaphylactic conditions such as urticaria, asthma, hay fever, food idiosyncrasies, etc., the autonomic system is greatly disturbed. These conditions are associated with parasympathetic hyperirritability as well as physical and chemical alterations in the cell. Lessened alkalinity in the cell makes it more reactive to sympathetic excitation. An increase of calcium does likewise, and calcium is thought by Lilly[7] to decrease the permeability of the cell membrane. An increase of potassium over the calcium in the cell favors parasympathetic excitation.

In anaphylactic conditions, manias, melancholias, and dementia praecox an interesting phenomenon called by Widal[8] the "haemoclastic crisis" occurs. If an individual ingests 200 grams of milk on a fasting stomach a leucocytosis occurs within forty minutes normally. In the majority of the above mentioned conditions a leucopenia instead of a leucocytosis occurs. This abnormal reaction can be prevented by a previous injection of atropine or adrenalin before the ingestion of the milk. The "haemoclastic crisis" is thought to be due to changes in the colloidal equilibrium of the body, and this change in equilibrium can be stabilized by altering the tone of the autonomic nervous system.

And finally, the presence of a chronic organic disease or toxemia must be eliminated. Pottenger[9] has demonstrated sympathetic stimulation in pulmonary tuberculosis.

The autonomic system may be studied first by mechanical tests, and then by pharmaco-dynamic tests.

It is well to have asked the patient about such symptoms as fatigue, insomnia, and inability to concentrate, attacks of dizziness, palpitation, dyspnea, and spells of emotional tension associated with polyuria and diarrhea.

The patient should be examined in a room free from draughts, and of a temperature comfortable to the bare skin.

The color, moisture, and temperature of the skin on various parts of the body should be noted. In vegetative excitement cold, moist hands and feet, a rapid pulse, moderately dilated pupils, profuse sweating of the armpits, and a tendency to restlessness and tremor are characteristic observations.

If sympathetic hyperexcitability in a given organ is found, that does not mean that the entire autonomic system is showing sympathetic excitement. Each organ must be tested and evaluated individually.

The responses in the skin are usually tested first. In the skin one can study the vasomotor, pilomotor, and sweat secretion reactions. All of these are thought to have only sympathetic innervation.

By lightly stroking the skin with a blunt instrument the dermographic response is elicited. Several types are described. As the blood in the skin capillaries is pressed out, a white line appears at the point of stimulation. This line may become more intense by local vasoconstriction, and is called Sergent's white line. The more common response is for the vessels to go into rapid dilatation, producing a red line, which may spread laterally to produce a red flush. A pallor along the periphery of the red area is often seen, and is due to vasoconstriction of vessels at the periphery. This is the mixed red and white dermographia. An elevated urticarial type is called dermographia factitia. The latter type is abnormal and the other types, if pronounced in degree or persists from twenty to thirty minutes, are also considered abnormal. Dermographia is abnormal in many cases of autonomic imbalance and in irritative lesions of the spinal sympathetic centers.

Temple Fay[10] has found the vasomotor reflex useful in localizing the level of cord tumors. He places a hot towel over the chest and abdomen until the skin is red. Upon removal of the heat, the skin at the segment corresponding to the upper level of the cord lesion remains hypermic after the skin above has become normal. The skin below the level of the lesion remains hyper-

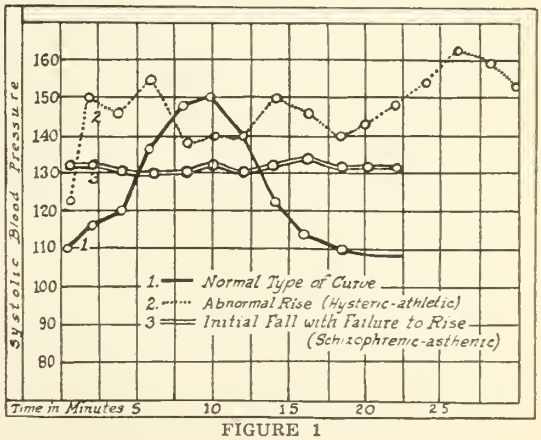


FIGURE 1

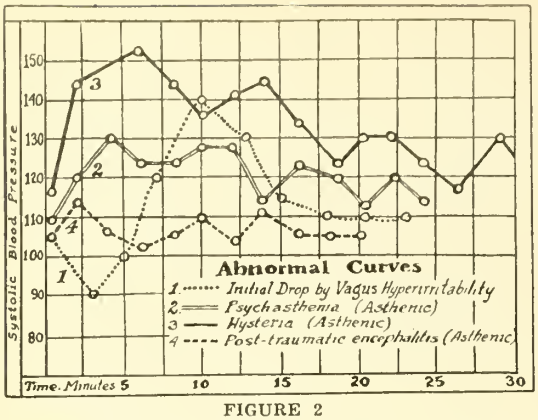


FIGURE 2

Atropine Sulph. Dosage	Position	Pulse Rate	Time	Remarks
	Lying	104	0	
	Standing	116	2	Sympathetic Stimulation
	Lying	100	5	Vagus Stimulation
1.2 Mg. Intram.			10	
	Lying	120	20	Vagus tone less
	Standing	148	25	Orthostatic tachycardia
	Lying	128	30	Vagus tone decreased
.6 Mg. Intram.				
	Lying	128	40	
	Lying	128	44	
	Standing	156	50	Orthostatic tachycardia
	Lying	128	56	Vagus completely blocked
Results. Sympathetic Tone		128		116 to 128 } Normal Values
Vagus Tone		24 (128-104)		48 58 } (Damelopolu and Carniol)
Orthostatic Tachyc.		156		130 140 }
Conclusion	Decreased Vagus Tone—Increased Sympathetic Tone			

FIGURE 3

emic, but less so than at the most upper portion which corresponds to the zone of hyperalgesia in the sensory tests.

The pilomotor response or goose flesh reaction may be seen along the line of stimulation when testing for dermographia. It is of no clinical significance. The pilomotor reflex extensively studied by Andre-Thomas[11] is of greater importance. This reflex is unilateral when elicited from one side of the body. It may be produced by deep pinching, applying ice, or by stimulation with a painful faradic current in the region of the border of the trapezius muscle in the neck. The stimulus must be strong enough to produce a disagreeable shiver or thrill. The goose flesh appears after a short interval following the stimulus, down the entire body to the feet. It may be elicited from below by scratching the soles of the feet. This test is more easily obtained following a dose of pilocarpine. In destructive lesions of the spinal cord as in a cord tumor, or compression syndrome especially in the upper dorsal region, the pilomotor reflex disappears below the level of the lesion. The reflex overlaps the level of the lesion by two or three segments whether elicited from above or below. The absence of the reflex depends upon destruction of the lateral horn sympathetic neurones. It is not absent in meningo-myelitis, amyotrophic lateral sclerosis, and in poliomyelitis except in the early stage. The test is, therefore, useful in differentiating tumor from disease. The spontaneous presence of a zone of goose flesh indicates an irritative reaction of the sympathetic fibres in the corresponding segments. The pilomotor reflex is often absent in the skin distribution of a paralyzed nerve.

Increased sweating is produced by sympathetic excitation. Disturbances in sweating are common in both functional and organic nervous diseases. In areas that have lost their sympathetic nerve supply, sweating is frequently absent. For example, sweating may be absent below the level of a spinal cord tumor just as the pilomotor reflex is absent, or it may be absent in the skin distribution of a paralyzed peripheral nerve. Contralateral sweating frequently occurs in internal capsular lesions. Generalized sweating in Parkinsonism and hyperthyroidism is common. The changes in sweating in peripheral polyneuritis and syringomyelia may be very striking.

Reflex vagus stimulation by slowing the pulse rate is the basis of a number of tests on the nervous mechanism of the heart. The pulse rate may be slowed by firm pressure on both eyeballs; the oculo-cardiac reflex, by firm pressure on both carotids in the neck at the level of the bifurcation; the carotid reflex, by firm pressure over the solar plexus; the epigastric or solar reflex, and by bending over slowly from the upright position, which increases the intracranial pressure and reflexively stimulates the vagus nerve. Slowing of the pulse by deep inspiration is common in children and is called juvenile arrhythmia. If the pulse is slowed twelve to fifteen beats per minute, or is either stopped for a few seconds, or made more rapid by any of these tests, it shows abnormal vagus irritability. These tests are of no value in organic heart diseases. They may or may not be present in autonomic imbalance.

A few tests are useful in studying the autonomic innervation of the pupil. In the absence of strong light or accomodation, the variation in tone of the sympathetic and parasympathetic nerves produce a rhythmic contraction and dilatation of the pupil, the so-called hippus phenomenon. It is excessive in children, and in autonomic imbalance states. Dilatation of the pupil produced by deep pressure over the solar plexus, by deep inspiration, and by painfully pinching the neck are sympathetic irritability tests.

The reflexive tests on the heart and pupil must be evaluated in terms of the total clinical picture.

The pharmaco-dynamic tests employ drugs that have a specific action on the autonomic system. The reaction of some of these drugs are variable because of the neuro-cellular and chemical factors discussed above. The action of adrenalin chloride and atropine sulphate have been found the most

constant in action for practical use. Experimental work is being done with acetyl cholin, ergotamine, eserine and other drugs, but the results are variable.

Adrenalin stimulates the sympathetic nerve endings at the myoneural junction. A few drops of a 1-1000 solution of adrenalin dropped into the eye normally produces no effect. If a dilatation of the pupil occurs within a few hours, it shows sympathetic hyperexcitability. The other eye should be used as a control. This is Löwi's pupillary reaction.

The effect of adrenalin on the pulse and blood pressure is the most constant guide to its systemic action. Intramuscular injection is the most satisfactory. The dosage is .5 to 1 cc. depending on the size of the patient. Subcutaneous injection interferes with absorption, because of vasoconstriction in the poorly vascularized subcutaneous fat. The blood pressure and pulse rate is taken every two minutes for thirty minutes following injection. An increase of pulse rate of one-third over the initial rate, or a rise of systolic blood pressure of thirty to forty Mm. of Hg. is considered abnormal. The maximum rise in systolic blood pressure occurs in about ten minutes. If it falls initially or rises more abruptly with a prolonged peak, a disturbance of the cardiac or vasomotor mechanism is indicated. A failure to rise is also abnormal. As stated above the bodily build of the patient modified the reaction to some extent. Fig. 1 and Fig. 2 show graphically some normal and abnormal reactions. During the test the patient may show restlessness, anxiety, tremor, blanching, palpitation, sweating, sighing, respiratory arrhythmia, and labile emotionality. Failure of a rise in blood pressure has been observed by Wolff and Thomas[12] in gastric neuroses, and the writer has observed the same reaction in the asthenic psychoneuroses and in schizophrenia.

The action of atropine sulphate is best studied by blocking the parasympathetic (vagus) innervation of the heart. The orthostatic clinical test of Danielopolu and Carniol[13] is the best test.

The vagus nerve by its tonic influence slows the pulse. The pulse rate will increase if this influence is removed by atropine. The pulse rate will also increase by changing from the lying to the standing position as the result of sympathetic stimulation. Therefore, if we give a patient atropine and compare the pulse rate at intervals while lying down and standing up, we will reach a point where the pulse rate, while lying down, remains the same on successive occasions. This means that the vagus is completely blocked. The only effect on the pulse rate then will be by sympathetic stimulation, the orthostatic tachycardia. Fig. 3 shows the results of this test in a case of vegetative imbalance following the toxemia of pregnancy.

The dosage of the drug necessary averages from 1.2 mg. to 2.2 mg. by intramuscular injection. The sympathetic tone is the maximum pulse rate in the lying position. The vagus influence is found as shown by subtracting the initial lying pulse rate. The orthostatic tachycardia is the standing pulse rate after complete vagus paralysis with atropine. The normal values are shown. This test is useful in differentiating functional from organic cardiac conditions.

A good many special tests are used by students of vegetative neurology. Only one need be mentioned which is of practical value. Adson[14] uses this test in studying the circulation in vasospastic conditions of the extremities, such as Raynaud's disease. He induces fever with a foreign protein, i.e., typhoid vaccine, and then compares the rise in mouth temperature with the rise in the surface temperature of the extremity. Normally, the surface temperature will increase from two to ten times more than the amount of increase in mouth temperature. If that amount of increase of the surface temperature in the diseased extremity does not occur, he does not believe that a sympathetic ganglionectomy will be justifiable.

It has been the aim in this paper to show that the neurological examination is not complete unless the autonomic nervous system is examined, and that clinical progress in the future will depend upon correlating such objective observations with the complex physiological factors underlying nervous diseases.

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Focal Infection As a Factor In Heart Disease

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ALL possible etiologic factors in cardiac failure warrant thorough consideration since heart disease is today by far the most frequent cause of death. Clark[1] states that in the year 1928 the number of deaths from heart disease in certain states having an aggregate population of 25,000,000 was 228 per 100,000 persons as compared with 106 from kidney disease, 105 from cancer and 100 from pneumonia. He adds that the number of deaths from heart disease in the registration area of the United States doubled during the eight year period from 1917 to 1925, while the population increased by only one-third.

Many deaths from heart disease are due primarily to valvular disease resulting for the most part from activity of the virus of rheumatic fever. In other cases, death results from vascular syphilis or is the end result of arterial hypertension. A very large proportion of the deaths from heart disease result, however, from chronic changes in the myocardium which we group under the term chronic myocarditis, or chronic myocardial degeneration, often ascribed to senescent changes. Impairment of the blood supply secondary to coronary artery disease is an important factor in the development of the myocardial changes. Often, however, the cause is not apparent. I wish to emphasize one possible factor, namely, chronic focal infection, which is often overlooked or its importance underestimated.

Rheumatic infections of the heart valves and heart muscle are focal in origin in the sense that they usually metastasize from infection in the nasopharynx. These infections occur typically at an early age although their effects may be apparent only late in life. The proper care of tonsil and dental infection has seemingly definitely decreased the incidence of rheumatic fever and consequently of rheumatic heart disease. It is not, however, the virus of rheumatism which I wish to discuss and emphasize but other infections of focal origin, largely streptococcic in type.

All students of heart disease are aware of the effect of infection on the heart muscle. It may be accepted as axiomatic that in every acute infection a certain degree of myocardial degeneration takes place. Recovery from this change may be complete but often the acute disturbance in the heart muscle is followed by fibrosis or scar tissue formation in the myocardium. It is probably for this reason that chronic fibrous myocarditis is the heart lesion most commonly observed. The acute myocarditis seen so often in diphtheria and the characteristic carditis of rheumatic fever and chorea are known to every one. Other types of infection might be mentioned in which manifest acute involvement of the myocardium is frequently seen. These types are easily recognized. The slow chronic poisoning from a focus of infection is less spectacular and not so easily recognized but is equally disastrous in its end results.

Under the head of focal infection I do not include the infections of rheumatic fever as these are not due to a chronic focal infection in the commonly accepted use of the term although they usually arise in nasopharyngeal lymphoid tissue. Rheumatic infections occur usually before the age of 30. It is after this period that chronic septic foci are much more common and most disastrous. Few of us escape them. Dental infection increases at this period, tonsil infection may continue, and infections in the gall bladder, the sinuses, the cervix, the prostate, and the appendix may develop. From such areas, absorption of bacteria and their toxins may go on for a long period, often for years, with constant damage to the heart.

A chronic focal infection is practically always due to the non-hemolytic streptococcus. Such an infection does not cause the primary valvular disease which is typical of the rheumatic virus, but may give rise to bacterial infections of valves already damaged by the rheumatic virus. Typically and most frequently, however, focal infections cause chronic myocardial disease, which is characterized by degeneration of muscle fibers and replacement by fibrous tissue. The action is essentially the same as that occurring in the case of various acute infections. The action is slower and more prolonged but the final result is much the same. In chronic joint disease we appreciate the effect of long continued absorption from a chronic focus of infection but often forget that the myocardium may be similarly affected over a long period of time resulting in a chronic fibrosis. The marked effect of such infection is often brought to light by the added element of some other acute infection such as influenza, which removes the final margin of safety.

Further proof concerning the relation of septic foci to heart disease may be adduced experimentally by:

(1) The results of injection of animals with bacteria from septic foci; (2) attempts in selected cases to reproduce in animals the heart lesion from which the patient suffers by the injection of bacteria recovered from foci in the patient; and (3) therapeutic results obtained by the removal of foci from patients suffering from heart disease presumably of focal origin.

In studying some problems in dental focal infection I injected 1500 rabbits intravenously with

Read before the Annual Meeting of the Fifth District, Cleveland, September 18, 1931.

TABLE 1
Localization of bacteria isolated from dental infection.

No. of animals	No. of patients	Percentage of animals showing lesions in:							
		Joint	Kidney	Muscle	Endocardium	Myocardium	Brain	Eye	Stomach & Duodenum
1500	501	58	30	21	18	10	4	14	16

bacteria from periapical infection. The organisms were principally nonhemolytic streptococci. Each animal received 5 c.c. of a 24-hour broth culture and was autopsied in from three to six days. The organisms were grown under partial oxygen tension (Fig. 1), a point most important in preserving pathogenicity during the period intervening between removal of the bacteria from the body and the injection of it into the experimental animal. All gross lesions observed at the routine autopsy were tabulated (Table 1). In this series, 18 per cent showed gross endocardial lesions and 10 per cent showed lesions in the myocardium. The lesions recorded are only those which are visible to the naked eye (Fig. 2). If microscopic studies had been made the incidence of lesions in the myocardium would certainly have been much higher. The myocardial lesions observed were hemorrhage, sometimes limited to the right auricle, areas of necrosis of the heart muscle, and occasionally small abscesses. It seems apparent from such results that the organisms in chronic septic foci are well able to produce disease of the myocardium and heart valves.

The results of animal inoculation with organisms recovered from chronic foci in patients suffering from heart disease of probable focal origin are best illustrated by case reports. The following are typical examples:

CASE 1

ACUTE MYOCARDITIS

D. H., a medical student, twenty-four years of age, stated that he had had several acute attacks of rapid heart beginning at the age of twelve years. There was no history of coincident infection at the onset. At the age of eighteen an attack occurred while the patient had an abscessed tooth. In May, 1925, he had an attack lasting several hours during which electrocardiograms were taken. These showed the tachycardia to be of a ventricular type (Fig. 3, A). For several weeks before this attack he had had an infection around a partially erupted third molar tooth. A second electrocardiogram taken in June, 1925, showed a normal heart rate but evidence of myocardial disease (Fig. 3, B).

At this time the third molar tooth was removed, revealing a pocket of pus from which a pure culture of a streptococcus was obtained. Two rabbits were injected with this culture. One died forty-eight hours later. At autopsy numerous areas of hemorrhage were found in the heart muscle (Fig. 3, D). The other animal was killed and at autopsy a smaller number of hemorrhages were found in the heart muscle.

In October, 1925, the patient died during another attack. At autopsy the heart showed no gross lesions. Sections, however, showed areas of acute infection in the heart muscle (Fig. 3, C).



Fig. 1. (A) Culture from periapical dental infection in glucose-brain agar. Note the uniform growth of colonies throughout the tube; (B) Culture similarly made in which the organism present will grow only under partial oxygen tension as shown by the absence of growth at the top of the tube; (C) Photomicrograph of characteristic nonhemolytic diplococcus from dental infection.

CASE 2

ACUTE AURICULAR FIBRILLATION

H. B. D., a banker, sixty-five years of age, had been having attacks of acute auricular fibrillation for only a short period of time. He had otherwise been in excellent health. The general physical examination was negative except for the heart condition. He had had some indefinite gastric symptoms. There was no hypertension. The dental radiographs showed three pulpless teeth only one of which showed radiographic evidence of infection. All three teeth were extracted. Only two, the upper right and left second bicuspids (Fig. 4, A) were cultured. Both showed a profuse growth of streptococci.

Two animals were injected with 5 c.c. each of the broth culture of the streptococcus recovered from the upper right second bicuspid. One animal was killed five days later. The examination showed a large vegetation on the tricuspid valve (Fig. 4, B) and hemorrhages in the myocardium. There were also hemorrhages in the first part of the duodenum, a few cortical kidney abscesses,

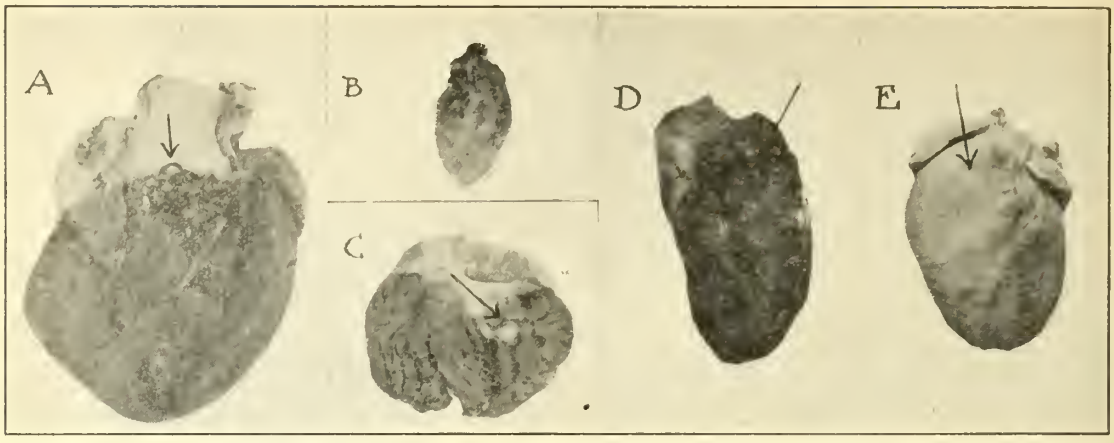


Fig. 2. Heart lesions in the rabbit produced by the intravenous injection of bacteria from periapical dental infection. (A) vegetations on aortic valve; (B) pericarditis; (C) large vegetation on mitral valve; (D) multiple hemorrhages in right auricle; (E) massive necrosis of wall of right ventricle.

purulent fluid in the large joints, and some areas of necrosis in the muscle. The second rabbit was killed six days after injection. There were vegetations on the tricuspid valve and in the right auricle (Fig. 4, C). The joints showed very slight involvement. There was one small abscess in the medulla of one kidney and some necrosis in the muscle.

Two rabbits were also injected with the diplococcus recovered from the upper left second bicuspid. In one, hemorrhages were seen in the papillary muscle of the left ventricle (Fig. 4, D), vegetations and hemorrhages in the endocardium of the right auricle, and same infection around the joints. The other animal showed vegetations on the heart valves and some small focal lesions in the myocardium. A few lesions were also found in the kidney medulla and there was involvement of the joints and muscles.

CASE 3

ACUTE MYOCARDITIS AND PHLEBITIS

J. W. P., a physician, sixty years of age, had had a phlebitis of the left femoral vein in 1904 following an acute alveolar abscess. Following this there were frequent flare-ups of the dental infection without further signs of systemic disease. In 1914 he began to have anginal attacks which continued up to 1916. These attacks were entirely relieved by the removal of an infected tooth. In March, 1923, the root of the bicuspid tooth became infected, and following this the patient had a recurrence of the phlebitis and anginal attacks. In June, 1923, nonhemolytic streptococcus was recovered from the blood. The patient became progressively worse, myocardial insufficiency developed, and death ensued. At autopsy multiple infarcts were found in the heart muscle.

After the extraction of the bicuspid root, the infection of which had initiated the present illness, cultures were made from the socket and two rabbits were injected. The culture showed only a green producing streptococcus. The rabbits at autopsy showed only endocardial vegetations and infarcts of the myocardium. The upper right second and third molars were extracted in July, 1923. A profuse growth of streptococci was obtained from both. Two rabbits were injected. One was dead the following morning. The autopsy revealed only multiple hemorrhages at the base of the valves. The second rabbit was dead forty-eight hours after injection. The examination showed only vegetations of the heart valve (Fig. 5).

CASE 4

MYOCARDITIS WITH ANGINA PECTORIS

L. B. N., a carpenter, forty-two years of age, complained of recurrent attacks of pain over the heart. The attacks had begun eight months previously, were always brought on by exertion, and were relieved by rest. During one attack the left arm felt numb. The patient had always been well before the present illness. On examination numerous extrasystoles were noted. The blood pressure was 100/75. No anemia was present. The blood Wassermann was negative. The urine showed no albumen, sugar or casts. There were numerous pulpless teeth and the tonsils were large and red. The fluoroscopic examination showed the heart and the aorta to be of normal size. The tonsils were removed and the pulpless teeth extracted. After the extraction of the teeth the patient felt so much better that he wished to return to work. Two weeks later he began to have dyspnea which increased in severity. He complained of a feeling of pressure in the chest, and a pericardial friction rub developed. Signs of myocardial insufficiency soon developed followed by death about one year after the onset of symptoms.

Two rabbits injected with the broth culture from the tonsils showed no lesions of any kind. Three *X*-ray positive teeth, the left lower first and second bicuspids, and the first molar were extracted. All showed a profuse growth of streptococci. Two rabbits were injected and killed three days after inoculation. One showed only an arthritis with a pyelonephritis. The other showed a marked necrosis of the myocardium involving

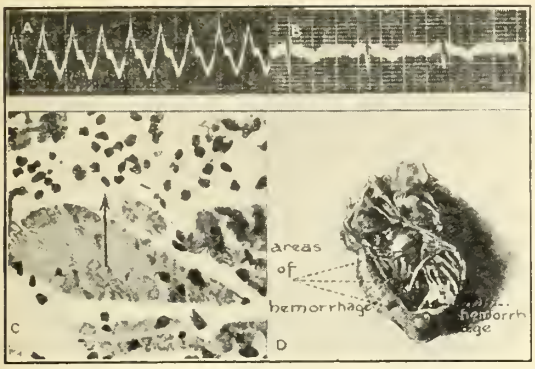


Fig. 3. (A) Electrocardiogram of patient (Case 2) taken during an attack of paroxysmal tachycardia; (B) electrocardiogram of same patient taken one month after the attack; (C) photomicrograph of patient's heart muscle obtained at autopsy. Note the area of polymorphonuclear infiltration; (D) heart of rabbit injected wtih streptococcus from an abscess around a partially erupted third molar tooth of the patient.

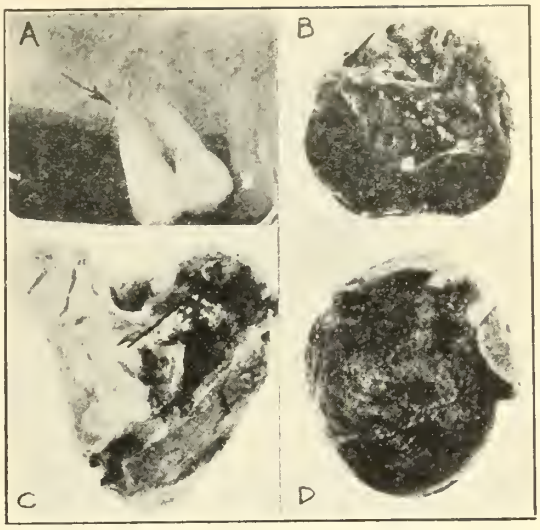


Fig. 4. (A) *X*-ray negative of pulpless tooth of patient (Case 2) which showed a profuse growth of streptococci on culture; (B) vegetations on tricuspid valve of rabbit injected with culture; (C) heart of another rabbit similarly injected showing multiple vegetations and hemorrhages in the wall of the auricle; (D) hemorrhage in myocardium.

almost the entire right ventricle (Fig. 6). A slight joint involvement was the only other lesion present.

One week later four more teeth were extracted. The left upper first bicuspid and lateral incisor were *X*-ray positive and showed a profuse growth of streptococci on culture. The left upper was negative in the radiograph and showed also a profuse growth of streptococci. The left upper cuspid showed only a few colonies in the agar tube and was negative in the radiograph. Two rabbits were injected with the mixed culture. One showed at autopsy slight joint lesions and yellow plaques in the arch of the aorta. The other showed lesions in the joints and muscles, marked necrosis of the heart muscle and several vegetations on the mitral valve.

The tendency of bacteria recovered from active dental infection in patients suffering from heart disease of focal origin, to cause valvular and myocardial lesions in the experimental animal is striking and adds evidence of a causal relation of the septic foci to the systemic lesion. The results in a group of patients with heart and vascular disease so studied are shown in Table 2.

Little evidence concerning the causal relation of chronic focus to the heart affection is obtained from the results of removal of septic foci. In acute cases there may be a striking therapeutic result. All too often no evident good results are obtained from the removal of the focus because the heart lesion has developed over a long period of time with permanent damage which may not be undone. Here the most to be hoped for is the prevention of the extension of the injury.

The important lesson to be learned from a study such as this is the realization on the part of the clinician of the potential danger to the heart of chronic septic foci. If this is kept in mind the importance of removal of focal infection early instead of late is apparent. There seems to be no doubt that the judicious removal of septic foci will do much to lessen the incidence of heart disease especially of the myocardium. In patients in whom the heart valves are already damaged by the rheumatic virus the removal of foci of infection should lessen also the incidence of subacute bacterial endocarditis. Early removal of chronic foci cannot be stressed too strongly in all

TABLE 2

Localization of bacteria from dental infection in heart and vascular disease.

Group	No. of animals	No. of patients	Percentage of animals showing lesions in:							
			Joint	Kidney	Muscle	Endo-cardium	Myo-cardium	Brain	Eye	Stomach and duodenum
I*	1210	405	60	32	22	17	9	5	14	14
II†	40	10	60	25	22	63	50	2	8	14

* Group I. Animals inoculated with dental cultures from patients not known to be suffering from heart or vascular disease.

† Group II. Animals inoculated with cultures from teeth of patients suffering from heart or vascular disease.

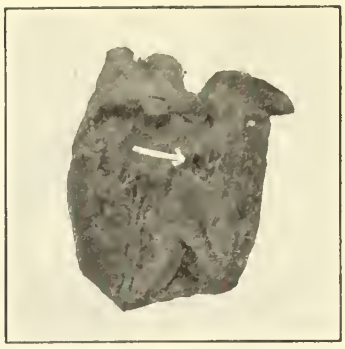


Fig. 5. Vegetation on heart valves of rabbit injected with cultures in Case 3. This heart also showed necrosis of heart muscle.

diseases of focal origin. Too often the late removal is disappointing and the importance of chronic foci is underestimated because the systemic disease, although of focal origin, is beyond repair. Systemic disease of focal origin should be cured before it develops.

SUMMARY

Chronic infection in teeth, tonsils, gall bladder, genito-urinary tract, and sinuses is an important factor in the causation of disturbances of the myocardium and in secondary infections of the heart valves.

Organisms recovered from chronic foci of infection caused heart lesions in a large percentage of rabbits injected intravenously.

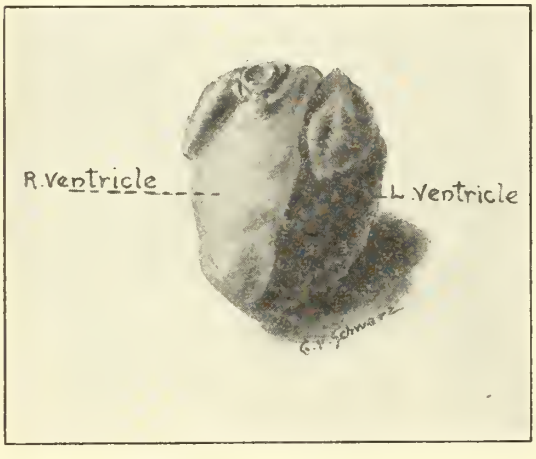


Fig. 6. Massive necrosis of almost entire ventricle of rabbit injected with culture from the infected teeth in Case 4.

Bacteria obtained from chronic foci in patients with heart disease due to focal infection produced heart lesions in a very high proportion of rabbits injected intravenously.

The therapeutic results of late removal of chronic foci are disappointing because the lesion caused by the focus is so often permanent.

The early removal of chronic foci should lessen the incidence of heart disease.

CLEVELAND CLINIC.

REFERENCE

1. Clark, T., Heart Disease: A public health problem, Pub. Health Rep., 44:2463-2467, 1929.

Decrease in Ohio's Death Rate and Diseases Tabulated

Ohio's general death rate for the calendar year 1931 was 11.2 per 1000 population, the lowest recorded for any year since the establishment of the Bureau of Vital Statistics in 1908, according to a recent announcement of I. C. Plummer, chief of the Bureau, State Department of Health.

During 1931, 75,577 deaths in the state were recorded, compared to 76,216 in 1930, when the rate was 11.4.

The greatest reduction in any single cause of death was found in accidents with 1065 fewer than in 1930. Fewer deaths from nephritis, diarrhea and enteritis (under two years of age), diseases of the heart, typhoid fever, smallpox, acute anterior poliomyelitis, epidemic meningitis, tuberculosis and the puerperal state were recorded. Increases were noted in deaths caused by influenza, cerebral hemorrhage, pneumonia, cancer, suicide, scarlet fever, diphtheria and diabetes.

Following is a tabulated comparison of the causes of deaths, with rates per 100,000 population, for 1930 and the provisional figure for 1931:

	No. 1930	No. 1931	Rate 1930	Rate 1931
Typhoid fever	236	164	3.53	2.43
Smallpox	14	3	.21	.04
Measles	181	145	2.71	2.15
Scarlet fever	173	223	2.59	3.30
Whooping cough	204	161	3.05	2.38
Diphtheria	160	189	2.40	2.80
Influenza	1340	1956	20.08	28.95
Acute Anterior poliomyelitis	112	52	1.68	.77
Lethargic encephalitis	62	70	.93	1.04
Epidemic cerebrospinal meningitis	131	102	1.96	1.51
Rabies	5	2	.07	.03
Tuberculosis (all forms)	4233	4195	63.37	62.09
Cancer (all forms)	6883	7013	106.06	103.79
Diabetes	1445	1468	21.63	21.73
Diseases of the nervous system	1925	1502	28.82	22.23
Cerebral hemorrhage	7009	7393	104.92	109.42
Diseases of the heart	15200	14962	227.54	221.44
Diseases of circulatory system	2005	2166	30.02	32.06
Diseases of respiratory system	736	668	11.02	9.89
Pneumonia (all forms)	5068	5264	75.87	77.81
Diseases of digestive system	4334	4036	64.88	59.73
Diarrhea and enteritis (under 2 years)	1074	790	16.08	11.69
Nephritis	5316	5013	79.58	74.19
Diseases of the genitourinary system	1098	858	16.44	12.70
The puerperal state	677	643	10.13	9.52
Malformations and diseases peculiar to early infancy	4016	3664	60.12	54.23
Suicide	1171	1238	17.53	18.32
Homicide	623	577	9.32	8.54
Conflagration	394	40	5.90	1.59
Accidental burns (conflagration excepted)	354	274	5.30	4.06
Acidental falls	1495	1200	22.38	17.76
Railroad accidents	461	273	6.84	4.04
Streetcar accidents	106	72	1.58	1.07
Automobile accidents	2063	1952	30.88	28.89
Other accidents	1934	1831	28.96	27.10
Total accidents	6707	5642	100.40	83.50
All other causes	4078	5418	61.04	80.19
Totals and rates	76216	75577	1140.95	1118.54

EIGHTY-SIXTH ANNUAL MEETING

Dayton, May 3 and 4, 1932

OHIO STATE MEDICAL ASSOCIATION

DAYTON-BILTMORE HOTEL

GENERAL SESSIONS

Opening Session

Tuesday, May 3, 9:30 A. M.
Meeting Place—Junior Ballroom, south end fourth floor, Dayton-Biltmore Hotel.

This session is combined with the first session of the House of Delegates. See page 282.

Second Session

Tuesday, May 3, 6:30 P. M.
BANQUET
Meeting Place—Dayton-Biltmore Hotel
Toastmaster—Charles H. Tate, Dayton, Chairman Local Entertainment Committee.

1. Annual address of the President-Elect, H. M. Platter, Columbus.
2. Annual address of the retiring President, D. C. Houser, Urbana.
3. Presentation of Past-President's Gavel to Retiring President—Dr. C. W. Waggoner to Dr. D. C. Houser.
4. "Civics for Civilized Men", an address by guest-speaker, John B. Kennedy of Collier's, editor and popular broadcaster in "Collier's Hour".
5. Informal reception in honor of the President and President-Elect. Dancing—preceded by special entertainment during the evening.

Third Session

Wednesday, May 4, 1:00 P. M.
Meeting Place—Main Ballroom, fourth floor, Dayton-Biltmore Hotel.

Program Presentation by
THE COLLEGE OF MEDICINE
UNIVERSITY OF CINCINNATI

SCARLET FEVER ANTITOXIN IN THE TREATMENT OF SCARLET FEVER—by F. E. Stevenson, Professor, Department of Pediatrics.

A report of a carefully controlled clinical study of the therapeutic value of Scarlet Fever Antitoxin. At the beginning alternate patients were treated with antitoxin A and every other patient was placed in the control group. With the addition of antitoxin B patients were divided into three groups, one receiving antitoxin A, the second became the control, and the third receiving antitoxin B. Lantern slides.

THE POSITION OF AUTOGENOUS VACCINES IN MODERN THERAPY—by Stanley E. Dorst, Associate Professor of Medicine.

A brief review of the development of vaccine therapy and of its decline in the esteem of the medical profession will be given. We will attempt to account for this fall from favor. It will be shown that, with our more recent knowledge of allergic manifestations in disease, vaccines must come to play an important part as therapeutic agents. We will outline what we believe to be a rational method of procedure in the selection and preparation of antigens for autogenous vaccines and also for their detoxification. This method seems to overcome most of the inadequacies which invalidated older methods and has been justified by exceedingly favorable clinical results in a wide range of diseases.

PLEA FOR EARLY DIAGNOSIS AND SURGICAL TREATMENT OF ACUTE GALL BLADDER DISEASE—by Max M. Zinninger, Assistant Professor, Department of Surgery.

A study of a group of patients with acute gall bladder disease showed that in a majority of them the acute attack failed to subside. The incidence of empyema, gangrene, and perforation of the gall bladder was high. Other authors report better results in cases where operation was done early than in those operated late for this condition. In view of these findings early operation is recommended for acute infection of the gall bladder.

Program Presentation by
THE COLLEGE OF MEDICINE
OHIO STATE UNIVERSITY, COLUMBUS.

SYMPOSIUM: DEFICIENCY DISEASES OF THE BLOOD.

I. Anemia.
   a. Experimental Studies—Ernest Scott, Professor of Pathology.
   b. Clinical Aspects—Geo. I. Nelson, Assistant Professor, Dept. of Medicine.

II. The Neutropenic State: Its Significance and Treatment—Charles A. Doan, Professor and Chairman, Dept. of Surgical Research.

The question of the hemoglobin-building factors in milk will be discussed in the light of the literature and experimental studies. The anemic state may be occasioned by a variety of organic or dietary deficiencies, which must be carefully differentiated in the individual case. The efficacy of treatment when properly prescribed is striking.

Varying degrees of neutropenia, both primary and secondary, are beginning to be recognized in clinical patients. The underlying etiology must be determined in each instance as a preliminary to successful therapy. A discussion of the relative merits of blood transfusion, irradiation and nucleotide therapy in the Schultz syndrome of malignant neutropenia or agranulocytosis will be presented with specific clinical examples. Lantern slides.

Program Presentation by
THE SCHOOL OF MEDICINE
WESTERN RESERVE UNIVERSITY, CLEVELAND.

THERAPEUTIC LAMPS—A CONSIDERATION OF THEIR PHYSICAL CHARACTERISTICS AS THE BASIS FOR THEIR THERAPEUTIC APPLICATION—by Henry J. Gerstenberger, Professor of Pediatrics.

Radiant energy produced by lamps of various kinds without question is a most valuable therapeutic agent and one that is rather extensively used by practicing physicians. It has been the observation of the essayist, however, that very few men really know what sort of rays are produced by the various lamps, what the physical characteristics of the rays are when tested for tissue permeability, and what their effect on physiological and pathological states are. Manifestly it is essential to the sound therapeutic application of the radiant energy produced by the rays to know the pertinent facts.

An attempt will be made to present important data in a concise, clear manner in order that the members of the Association may make intelligent use of them in practice.

Models of some of the lamps will be demonstrated in an illustrative manner. Lantern slides.

Fourth Session

FINAL SESSION OF THE HOUSE OF DELEGATES—ANNUAL ELECTION
(See detailed program and order of business).

OPENING SESSION AND HOUSE OF DELEGATES

First Session

Tuesday, May 3, 9:30 A. M.

Meeting Place—Junior Ballroom, south end fourth floor, Dayton-Biltmore Hotel.

In the chair, Frederick K. Kislig, President of the Montgomery County Medical Society. Presentation of the President, D. C. Houser. House of Delegates Order of Procedure:

1. *Call to order by the President.*
2. *Roll Call.*
3. *Consideration of Minutes of Previous Meeting* (Published in *The Journal*, June, 1931). (Reports submitted below, published in full in the May, 1932, *Journal).*
4. *Reports of Standing Committees:*
   (a) Public Policy—John B. Alcorn, Columbus, Chairman.
   (b) Medical Economics—J. Craig Bowman, Upper Sandusky, Chairman.
   (c) Publication—Andrews Rogers, Columbus, Chairman.
   (d) Medical Defense—J. E. Tuckerman, Cleveland, Chairman.
   (e) Medical Education and Hospitals—Ben R. McClellan, Xenia, Chairman.
   (f) Auditing and Appropriations—S. J. Goodman, Columbus, Chairman.
5. *Reports of Special Committees:*
   (a) Mental Hygiene—E. J. Emerick, Columbus, Chairman.
   (b) Periodic Health Examinations—V. C. Rowland, Cleveland, Chairman.
   (c) Military—Harry D. Jackson, Circleville, Chairman.
6. *Report of Officers:*
   (a) Treasurer's Report combined with report of Committee on Auditing and Appropriations.
   (b) Reports of Councilors as to the condition of the societies in their respective districts.
7. *Appointment of Committees:*
   (a) A Committee on the addresses of the President and President-Elect.
   (b) A Committee on Resolutions.
   (c) A Committee on Annual Reports.
   (d) A Committee on Credentials of Delegates.
   (e) A Committee of Tellers and Judges of Election.
8. *Nomination and Election of Nominating Committee:*
   (Nominations from the floor with one representative on the committee to be elected from each councilor district. This committee shall report to the Second Session on Wednesday afternoon, its recommendations in the form of a ticket, containing nominees for constitutional offices as required under the constitution. The President will issue instructions to the committee on the constitutional requirements).
9. *Introduction of Resolutions.*
   It is necessary that all resolutions introduced in the House of Delegates be referred to the Reference Committee on Resolutions and reported back to the House before action can be taken. All resolutions for consideration at this annual meeting must be introduced at this session and reported back to the House by the Reference Committee at the Wednesday afternoon session. All resolutions must be typewritten and submitted in duplicate.
10. *Aetion on Proposed Amendments to the Constitution and By-Laws* (published in the March, 1932 issue of *The Journal*, pages 199 to 201.)
    All amendments introduced from the floor to any of the proposed amendments already published, must be in writing—preferably typewritten, and in duplicate.
11. *Miscellaneous Business.*

Second Session

Wednesday, May 4, 3:30 P. M.

Meeting Place—Junior Ballroom, south end fourth floor, Dayton-Biltmore Hotel.

1. *Roll Call.*
2. *Continuanee of unfinished business from Tuesday's session of the House of Delegates,* including action not yet completed on proposed amendments to the Constitution and By-laws.
3. *Annual Election.*
   President-Elect. (One year. Nominations from the floor.
4. *Report of Nominating Committee.*
   (a) *Election of Members of Council.*
   Members of Council are elected for two-year terms, those representing odd numbered districts expiring in even numbered years. To be elected:
   Councilor, First District—Present incumbent, John A. Caldwell, Cincinnati.
   Councilor, Third District—Present incumbent, O. P. Klotz, Findlay.
   Councilor, Fifth District—Present incumbent, C. L. Cummer, Cleveland.
   Councilor, Seventh District—Present incumbent, E. B. Shanley, New Philadelphia.
   Councilor, Ninth District—Present incumbent, I. P. Seiler, Piketon.
   (b) *Election of Delegates and Alternates to the American Medical Association.*
   Three delegates and their respective alternates, (two years each).
   Those whose terms expire at this time are:
   Wells Teachnor, Sr., Columbus.
   D. H. Morgan, Akron. (alternate).
   Ben R. McClellan, Xenia.
   A. C. Messenger, Xenia. (alternate).
   E. R. Brush, Zanesville.
   ( ). (alternate).
   C. W. Stone, Cleveland.
   C. L. Cummer, Cleveland. (alternate).
   (The By-Laws of the American Medical Association provide: A member of the House of Delegates must have been a member of the American Medical Association and a Fellow of the Scientific Assembly for at least two years next preceding the session of the House of Delegates at which he is to serve. Delegates and Alternates from constituent associations entitled to more than one representative shall elect them so that one-half as near as may be, shall be elected each year.)
5. *Reports of Reference Committees:*
   (a) Committee on Addresses of President and President-Elect.
   (b) Committee on Annual Reports.
   (c) Committee on Resolutions.
6. *Selection of Place for Annual Meeting in 1933.*
7. *Miscellaneous Business.*
8. *Installation of Officers for 1932-1933.*
9. *Confirmation by House of Delegates of Committee Appointments announced by the newly-installed President.*
   (a) One Member of the Committee on Public Policy (Three years). (Member whose term expires, C. W. Stone, Cleveland.)
   (b) One Member of the Publication Committee (Three years). (Members whose term expires, Gilbert Micklethwaite, Portsmouth.)
   (c) One Member of the Committee on Medical Defense (Three years). (Member whose term expires, F. P. Anzinger, Springfield.)
   (d) One Member of the Committee on Medical Education and Hospitals (Three years). (Member whose term expires, R. H. Birge, Cleveland.)
   (e) One Member of the Committee on Medical Economics (Three years). Member whose term expires, E. O. Smith, Cincinnati.)
10. *Unfinished Business.*
11. *Final Adjournment of House of Delegates.*

Immediately following adjournment of the House of Delegates, Council meets for reorganization. The newly-installed president becomes chairman of Council and Council selects a secretary.

MEDICAL SECTION

LEO C. BEAN, Gallipolis ..... Chairman
CARLL S. MUNDY, Toledo ..... Secretary

First Session

Tuesday, May 3, 2:00 P. M.

Meeting Place—Main Ballroom, fourth floor, Dayton-Biltmore Hotel.

1. THE PROBLEM OF HYPERSUSCEPTIBILITY IN ECZEMA DERMATITIS — ITS RELATION TO INTERNAL MEDICINE—by Harold N. Cole, Cleveland.

The word eczema has been used since the time of Hippocrates. It is only in the last hundred years, however, that it has its present significance. In the past there has been a tendency to look upon an eczema as a disease of internal causation; any inflammation of the skin of external causation was generally classified as a dermatitis.

A discussion of the relation of the two conditions.

Modern significance of dermatitis in relation to external irritants of various types.

Methods of diagnosis.

Modern conceptions of eczema.

Present concept in regard to hypersusceptibility of the skin; its relation to anaphylaxis.

The treatment of eczema and dermatitis. Lantern slides.

Discussion—Elmore B. Tauber, Cincinnati, and C. J. Shepard, Columbus.

2. MIGRAINOUS-LIKE HEADACHES DUE TO ALLERGY—by Jonathan Forman, Columbus.

Certain individuals whose ancestry and kinsfolk have had one or several of the known allergic symptom complexes, who themselves present frequently one or several of these same manifestations, in whom an eosinophilia can be demonstrated, who give positive skin tests to certain substances, give a history of chronic recurring headaches for which they come seeking relief. Attention is called to our previous paper before this section in which complete classification and detailed discussion of differential diagnosis was presented. When properly identified, these individuals respond very well to non-allergic elimination dietary management as outlined by Rowe, accompanied, of course, with intelligent symptomatic treatment.

Discussion—Bernard Steinberg, Toledo, and Joseph Stein, Cincinnati.

3. HAY FEVER TREATMENT—THE CONTINUOUS METHOD—by Karl D. Figley, Toledo.

History of the method of perennial pollen desentization.
Definition of what is meant by continuous method.
Technic: Preliminary testing, strength and interval of pollen extract dosage, frequent retesting.
Number of cases and classification.
Duration of treatment necessary for permanent relief.
Constitutional Reactions.
Results.
Advantages over former methods of treatment.
Summary. Lantern slides.

Discussion—Milton B. Cohen, Cleveland, and Edward Sherrer, Cleveland.

4. HAS THE TREATMENT OF DIABETES MELLITUS BECOME TOO TECHNICAL?—by Louis G. Heyn, Cincinnati.

The literature of diabetes mellitus, always voluminous, was further stimulated when Allen's starvation treatment was advanced. Successive modification of dietetic management, and the discovery of Insulin has added enormously to the literature. Much light has been shed on diabetic therapy, but out of the maze of so many dietetic formulas and suggestions, is it not possible that we have become confused? Perhaps too many cooks have been preparing the diabetic broth and a simpler recipe may be advantageous.

Discussion—Henry John, Cleveland, and J. J. Coons, Columbus.

Second Session

Wednesday, May 4, 9:00 A. M.

Meeting Place—Main Ballroom, fourth floor, Dayton-Biltmore Hotel.

5. PHYSICAL IMPAIRMENT AMONG 3,000 MALE INDUSTRIAL WORKERS—by Floyd P. Allen, Public Health Federation, Cincinnati.

A review of findings derived in studies made by the Cincinnati Heart Council among industrially employed groups in the metropolitan area of this city. Interesting comparisons of data will be given with reference to economic status of the three groups, of 1,000 men each, and physical findings. Emphasis will be placed in this comparison upon cardio-vascular findings. The high incidence of physical defects found and yet unknown to examinees prior to examination should prove of interest.

Discussion—Wm. Muhlberg, Cincinnati, and Emery Hayhurst, Columbus.

6. THE EARLY RECOGNITION OF CARDIAC FAILURE—by L. A. Levison, Toledo.

Heart failure occurs at the time when the heart muscle is no longer able to maintain a sufficient circulation. The factors involved may be due to an embarrassment of the heart muscle or to anatomical changes in the muscle fibers. There have been many attempts to show that this breaking point is due to chemical factors in addition to those embarrassing the circulation.

Studies are made to determine the factors present in the medical history previous to and predisposing toward the final breakdown. Lantern slides.

Discussion—Frank Clifford, Toledo, and Julien Benjamin, Cincinnati.

7. ANGINA PECTORIS—HOW SERIOUS IS IT?—by John P. Anderson, Cleveland.

Why is it that some cases are serious while others seem to run a fairly mild course with remissions that may last several years?

An attempt will be made to bring out points helpful in this differentiation.

Discussion—Simon Morgenroth, Akron, and Stanley C. Schiller, Mansfield.

8. ERYTHROCYTE SEDIMENTATION RATE: A PRACTICAL APPLICATION AS A CONTROL FACTOR IN PULMONARY TUBERCULOSIS—by Warren C. Breidenbach, Dayton.

I. A brief resume of the most plausible theories as to causes of change in sedimentation rate. II. Conditions reported to give marked variations in rate with brief discussion of change. III. Technique of several methods. IV. Discussion of its use in pulmonary tuberculosis. V. Prognostic Use. VI. Diagnostic Value (Occasionally). VII. Office Use. VIII. Summary of cases. Graphic and divisional report on 300 tests run on 250 patients both of office and sanatorium type. IX. Conclusions.

Discussion—Walter M. Simpson, Dayton, and Robert K. Finley, Dayton.

SURGICAL SECTION

M. E. BLAHD, Cleveland ..... Chairman
CARL R. STEINKE, Akron ..... Secretary

First Session

Tuesday, May 3, 2:00 P. M.

Meeting Place—Ballroom, mezzanine floor, Miami Hotel.

1. NATURE OF CANCER—by B. S. Kline, Cleveland.

An epithelial cell or cells or an epithelial structure or structures isolated from the remainder of the lobule by certain physical, chemical or biological processes may change in type in the course of a number of cell generations in the altered environment. Certain of these isolated units deprived of innervation and lymph drainage become more and more independent of body influences and at the same time acquire a greater capacity for establishing connection with the regional blood supply and of growing more rapidly than the cells from which they arose. These adaptations in the course of a number of cell generations are re-

flected in chromatin alterations which may finally be characteristic of malignant transformation. Once fully developed, the cancer cells reproduce cancer cells and whatever the appearance of the unit or units at the time of malignant transformation, this is reproduced again and again in the primary and metatatic growths. Lantern slides.

Discussion—Mont R. Reid, Cincinnati, and H. Goldblatt, Cleveland.

2. CHOICE OF TREATMENT FOR MALIGNANCY OF THE SKIN—ITS RELATION TO SURGERY—by J. R. Driver, Cleveland.

A study of approximately 1500 cases of malignancy of the skin and mouth treated over a period of 15 years is presented. A comparison is made of the results obtained by various methods of treatment. These methods include radiation by *X*-ray and radium, electro-coagulation, actual cautery, curretage and surgical procedures. It is shown that often a combination of these methods is superior to any one procedure alone. Biopsy examinations are of great value in determining the best methods of treatment and are important in determining the prognosis. The greatest difficulties are encountered in the treatment of recurrences—these are discussed and recommendations made. Radio-sensitivity and radio-resistance are best determined by histological study. Management of metastases. Lantern slides.

Discussion—F. S. Gibson, Cleveland, and L. A. Pomeroy, Cleveland.

3. CANCER OF THE BREAST—by Andre Crotti, Columbus.

Some pathological considerations. Clinical discussion of some of the phases of cancer of the breast. Presentation of some anatomical and technical facts in dealing with cancer of the breast. Personal experiences. Remote results.

Discussion—L. L. Bigelow, Columbus.

4. THE USE OF OPAQUE OIL IN THE STUDY OF THE COMMON DUCT AND THE BILIARY TREE FOLLOWING CHOLEDOCHOTOMY—by Fred M. Douglass, Toledo.

The synopsis is as follows:

1. Postoperative study of 12 cases.
2. Its value in determining time to remove the tube.
3. Its use as a possibility of reducing postoperative pain.
4. Lessening morbidity.
5. Its value in consideration of prognosis.

Lantern slides.

Discussion—Clarence Hufford, Toledo, and J. L. Ransohoff, Cincinnati.

5. TRANSURETHRAL RESECTION OF THE PROSTATE; A CONSERVATIVE PROCEDURE—by Wm. E. Lower and Wm. J. Engel, Cleveland. (Extra Paper)

The ideal in medicine is to secure the maximum benefit with the minimum risk. In the study of our cases of transurethral resection of the prostate, we feel that this method offers the advantage of being conservative, economical, both as to time and expense, and gives the patient suffering from bladder obstruction urinary comfort. The paper also discusses the complications and the results, based upon an analysis of the cases done. Lantern slides.

Discussion—E. O. Smith, Cincinnati, and Hugh Baldwin, Columbus.

Second Session

Wednesday, May 4, 9:00 A. M.
Meeting Place—Ballroom, mezzanine floor, Miami Hotel.

6. ABDOMINAL SURGERY IN CHILDREN—by Norris W. Gillette, Toledo.

The conditions necessitating abdominal surgery in children are appendicitis, intussusception, intestinal anomolies, pyloric obstruction, hernia (umbilical, inguinal, and strangulated), defects of the abdominal wall, undescended testicle, retroperitoneal sarcoma, adhesions, foreign bodies in the intestines, extrophy of bladder, and anemias with splenomegaly.

Differential diagnosis. Indications for operation and technique.

Anesthetics best employed are spinal, avertin or ether.

Relative frequency of abdominal lesions requiring surgery.

Results of operative procedures.

Discussion—Homer H. Heath, Toledo, and Joseph L. DeCourcy, Cincinnati.

7. THE MANAGEMENT OF THE ACUTE ABDOMEN WITH SPECIAL REFERENCE TO THE USE OF SPINAL ANAESTHESIA—by Robert C. Austin, Dayton, and H. H. Wagner, Dayton.

The conditions largely responsible for the high mortality rate in "the acute abdomen", are acute appendicitis, intestinal obstruction, and perforation of upper abdominal viscera. Early diagnosis is important and grave responsibility rests upon the physician who first observes the patient. It is not necessary to make an accurate anatomical diagnosis, but it is essential to know that a grave surgical condition exists. Preoperative preparation should be emphasized. Spinal anesthesia is a valuable adjunct. The spinal anesthetist must be thoroughly trained in the technique and in the physiological factors involved. Comparative mortality figures in the experience of the authors and other surgeons are stated.

Discussion—J. Mitchell Dunn, Columbus.

8. THE RELATIVE IMPORTANCE OF NON-OPERATIVE AND OPERATIVE TREATMENT OF BONE TUBERCULOSIS—by Walter A. Hoyt, Akron.

The subject is discussed along the following lines: 1. Classification of bone tuberculosis. 2. Treatment by heliotherapy and conservative methods alone. 3. Treatment by operative methods alone. 4. Treatment combined by operative, heliotherapy and conservative methods.

Attempt is made to outline the ideal treatment of bone tuberculosis.

Paper is illustrated by lantern slides.

Discussion—Clarence L. Hyde, Akron, and Theodore A. Willis, Cleveland.

9. MODERN TREATMENT OF FRACTURES OF THE SKULL—by E. R. Arn, Dayton, and Roy D. Arn, Springfield.

The modern management of skull fractures differs remarkably from the forms of treatment which were in vogue two decades ago. Severe traumatism to the skull, resulting in fracture, was regarded as an indication for immediate surgical interference. Attention was directed primarily to the damage to the skull and little or no emphasis was placed upon the coexisting intracranial damage. During recent years it has been adequately demonstrated that the damage to the brain tissue is much more important than the damage to the skull.

The initial treatment should be that of the shock. Simple linear fractures of the base and vault should be treated conservatively. Depressed and compound fractures ordinarily require surgical treatment. Any evidence of hemorrhage from the venous sinuses or middle meningeal arteries require immediate operation.

Hypertonic solutions of glucose, magnesium sulphate or sodium chloride should be used for combating increased intracranial pressure. Repeated lumbar punctures are of equal importance. Lantern slides.

Discussion—William J. Gardner, Cleveland, and Verne A. Dodd, Columbus.

10. ABDOMINAL TUMORS, THEIR DIFFERENTIAL DIAGNOSIS BY THE *X*-RAY—by Samuel Brown, Cincinnati. (Extra Paper)

A radiological study of abdominal tumors and their differentiation. The abdomen is subject to a large variety of tumor formation. The early recognition of their presence is essential in order to render surgical help at a time when it may be of greatest benefit to the patient. The radiological method of investigation has advanced a great deal the possibility of an early diagnosis in a large number of cases. Improved methods of radiological investigation will be presented and a number of cases will be described in detail. Lantern slides.

Discussion—Samuel Zielonka, Cincinnati, and Joseph Heiman, Cincinnati.

OBSTETRICS AND PEDIATRICS

ELMER G. HORTON, Columbus ..... Chairman
B. H. CARROLL, Toledo ..... Secretary

First Session

Tuesday, May 3, 2:00 P. M.

Meeting Place—Junior Ballroom, south end, fourth floor, Dayton-Biltmore Hotel.

1. STUDIES IN RICKETS V. RELATION OF DIET DURING PREGNANCY TO THE DEVELOPMENT OF THE CHILDREN AT SEVEN YEARS OF AGE—by J. V. Greenebaum, A. G. Mitchell and T. K. Selkirk, Cincinnati.

Seven years ago the diets of twenty-five women were supervised during the latter half of pregnancy. Dietitians paid periodic visits to these women, advising them what to eat and keeping record of the articles and amounts of food actually ingested. The children born of these mothers were studied during infancy to determine the incidence of rickets. Cod liver oil was withheld during this period of observation. When the children were four years old the group was again studied with particular reference to the teeth. The present study deals with these children, now seven years old, to ascertain the condition of the teeth, state of nutrition and bony development. Lantern slides.

Discussion—S. D. Edelman, Columbus, and W. B. Taggart, Dayton.

2. DISLOCATIONS OF THE LOWER END OF THE SEPTAL CARTILAGE, A. IN THE NEWBORN (BIRTH INJURIES), B. IN THE INFANT, C. IN YOUNG CHILDREN—by Myron Metzenbaum, Cleveland.

This paper will deal with the recognition of traumatic displacements of the cartilaginous nasal septum at the (a) time of birth (birth injuries), (b) during infancy, (c) in early childhood. It will present an original diagnostic sign (the asymmetry of the nares) for the recognition of the dislocation of the lower end of the septal cartilage and a simple method for the reduction soon after injury. The paper will point out the importance of reducing the dislocated septal cartilage soon after the injury to insure normal nasal development and normal nasal function and to aid in the harmonious development of the upper and lower jaws, and to obviate later in life the submucous resection operation of the septum. It will also point out the possibility for resetting the old dislocated septal cartilage at any period during childhood and presents the author's method for the resetting of the dislocated septal cartilage. Lantern slides.

Discussion—M. Garber, Cleveland, and J. M. Ulrich, Akron.

3. CONGENITAL ABSENCE OF ABDOMINAL MUSCLES—by E. H. Baxter, Columbus.

Review of the literature. Incidence. Etiology. Possible embryological defects. Various types and degrees of deformity. Symptoms and physical findings. Care of patient during early months. Supportive devices. Case report. Lantern slides.

Discussion—D. C. Mebane, Toledo, and R. S. Friedley, Akron.

4. PNEUMOCOCCUS AND STREPTOCOCCUS MENINGITIS COMBINED. REPORT OF FIVE CASES WITH RECOVERY IN THREE—by S. H. Ashmun, Dayton.

Importance of early diagnosis and equal importance of early treatment with numoquin hydrochloride and neutral acriflavin. Role of cisterna magna drainage and of ventricular drainage. Pediatrists have changed the once hopeless prognosis to a fairly hopeful prognosis. Review of literature.

Discussion—Edward Wagner, Cincinnati, and J. P. Farson, Columbus.

Second Session

Wednesday, May 4, 9:00 A. M.

Meeting Place—Junior Ballroom, south end, fourth floor, Dayton-Biltmore Hotel.

5. DIABETES IN PREGNANCY—by Henry J. John, Cleveland.

Incidence of glycosuria in pregnancy as reported by various authors varies from 0.8 to 100 per cent. Various explanations are offered for this phenomenon. Obesity is probably the most potent factor in the incidence of diabetes during pregnancy. During pregnancy the utilization of galactose is depressed. The renal threshold in pregnancy is low—123 mg. per 100 cc. in my series. There is a hyperfunction of the thyroid, the adrenals, and the hypophysis during pregnancy. The fetal mortality in diabetic mothers is high. The diabetic condition of the mother improves during the latter stage of pregnancy. After parturition there is usually a retrogression of the diabetic state.

Diabetes is a fertile ground for toxemia of pregnancy and the pernicious vomiting of pregnancy may culminate in severe acidosis. The production of hypoglycemia by excessive doses of insulin may lead to the death of the fetus and bring about abortion. The ratio of the average size of babies born of diabetic mothers to those born of non-diabetic mothers is 100:71. Lantern slides.

Discussion—Cecil Striker, Cincinnati, and Theodore Miller, Cleveland.

6. A SURVEY OF 1253 CONSECUTIVE DELIVERIES—by C. T. Hemmings, Cleveland.

Many untoward remarks and assertions have been directed at the obstetrical world through lay journals, newspapers, and other sources.

This survey in consecutive order, which occurred at St. Luke's Hospital, Cleveland, Ohio, during the year 1930, represents a summary of the deliveries performed by seventeen interns and one hundred and twenty-two visiting physicians, most of whom are general practitioners endowed with various techniques developed in many different medical centers of this country. It includes definite statistics as to color, gravida, age, pelvis, length of labor, membranes, rectal and vaginal examination, presentation, type of delivery, cord length, cervical and perineal lacerations, placental delivery, hemorrhage, anesthetic, diagnosis, maternal morbidity, institutional complications, and maternal mortality. Fetal sex, weight, institutional complications, and mortality are also included. Lantern slides.

Discussion—Magnus A. Tate, Cincinnati, and W. G. Clagett, Dayton.

7. CAUSAL FACTORS IN POSTERIOR POSITIONS OF THE OCCIPUT—by Wm. D. Porter, Cincinnati.

The literature is markedly lacking. It is true that many empirical, unsupported statements may be found. Some of these are easily proved incorrect and some are even ridiculous. When we recall numerous instances of successive posterior positions in the same patient, it seems strange that no one has given more than casual consideration to this subject. The most prolific cause is an excessive sacro-vertebral angle—the so-called swayback condition. It is important to understand this condition as management in labor often requires good judgment and considerable skill.

Discussion—John A. Gardiner, Toledo, and Wm. P. Gillespie, Cincinnati.

8. THE OBSTETRICAL JOINTS—by G. Wayne Brehm, Columbus.

The joints of female pelvis during pregnancy, delivery and puerperium are seldom given much attention, yet they produce directly, as well as indirectly, a large percentage of the postpartum pain, aching, soreness, and dragging symptoms experienced by obstetrical patients.

Proper postures, supports, diets, measurements during ante partum care; proper positions, no exaggerated joint stress (especially while under anesthetic) or stretchings during labor; proper positions, exercises, supports, swathe or strapping if necessary (fect as well as pelvis), frequent examinations, etc., will eliminate many of these unpleasant symptoms, give us happier, mentally more composed, relaxed mothers more capable of nursing their babies and dreading less the future maternal experiences.

Discussion—L. E. Leavenworth, Canton, and O. W. Haulman, Youngstown.

9. MOTION PICTURE WITH SOUND—REPAIR OF SECOND AND THIRD DEGREE LACERATIONS OF THE PERINEUM AND RECTOCLE. (Extra)

Prepared at St. Luke's Hospital, Chicago, by Dr. Harold O. Jones, Associate Professor of Gynecology, Northwestern University, under a grant from Petrolagar Laboratories. The introductory discussion out-

lines the etiologic factors of these lesions as well as contributing conditions with complete description accompanying the operative procedure.

The description of the operative procedure deals with (1) a demonstration of the lesion pointing out the severed ends of the sphincter ani muscle, (2) location and extent of the incision, (3) details of dissection demonstrating again the relations and tissues used in the repair, (4) proper placing of sutures to properly repair these lacerations and (5) demonstration of end result.

EYE, EAR, NOSE AND THROAT

ALBERT L. BROWN, Cincinnati ..... Chairman
IVOR G. CLARK, Columbus ..... Secretary

First Session

Tuesday, May 3, 2:00 P. M.
Meeting Place—Roof Garden, Miami Hotel.

1. SYMPOSIUM ON OCULAR MANIFESTATIONS ASSOCIATED WITH HEAD CONDITIONS.

a. OCULAR STANDPOINT—by Wm. E. Bruner, Cleveland.

Cooperation between ophthalmologist and otologist is essential for successful ear work. Eye manifestations rarely give definite diagnosis of otic disease, but aid in diagnosis and localization. Particularly helpful in diseases extending from ear into neighboring tissues. Particularly true in internal ear lesions and brain complications.

Every otologist should be able to make gross eye examination to ascertain course of ocular manifestations. Should not, however, rely upon his findings for final diagnosis in obscure cases. Should always in such situation call for capable ophthalmologist. Careful ophthalmological examination is then essential. Courageous statement of findings and impressions on part of ophthalmologist great aid to careful otitic diagnosis, surgical measures and prognosis. Brief case records to illustrate.

Discussion—E. C. Cutler, Cleveland, and D. T. Vail, Cincinnati.

b. OTOLOGIC—by M. F. McCarthy, Cincinnati.

Importance of eye symptoms—both objective and subjective—in intracranial growths. Some of the modern aids in diagnosis. Tumors in the region of the sella, including cisternal arachnoiditis. The syndrome of homolateral optic atrophy or retro-bulbar neuritis, with contralateral papilledema. Homonymous hemianopsia as a symptom. Variations in cases of papillitis. Druzen neuritis, retained nerve sheath, and pseudo-neuritis, or other possible causes of papillitis must, as far as possible, be excluded before we can arrive at a diagnosis. Citation in some detail of several cases in the early and in the late stage, without any localizing symptoms, in which decompression effected an apparent cure.

Discussion—Albert Frost, Columbus, and C. C. Jones, Cincinnati.

c. SINUS INFECTIONS CAUSING OCULAR MANIFESTATIONS—by J. M. Waugh, Cleveland.

Milder forms of sinus infections are responsible for many cases commonly known as catarrhal conjunctivities. Other low grade ocular manifestations are the result of the plastic type of sinus infection, especially plastic ethmoiditis. When similar pathology occurs in the maxillary sinuses the same eye reactions may result. In these cases irrigation of the sinuses may fail to show any gross purulent or mucopurulent secretion, but immediate improvement in the eye condition follows. These changes are analogous to those in vaso-motor rhinitis cases which sometimes are benefited by sinus irrigations.

The more severe forms of ocular manifestations namely the peri-orbital inflammation, abscess formations, and the marked chorio-retinitis changes are usually due to pan-sinusitis rather than to the involvement of the single sinus. Various writers have been inclined to credit either the ethmoid or the sphenoid sinus with the responsibility for the ocular manifestations. It is my opinion that it is rarely the case that a single sinus infection occurs of such severity as to account for the major ocular manifestations referred to above. Lantern slides.

Discussion—W. H. Snyder, Toledo.

d. NEUROLOGICAL—by A. R. VonDerAhe, Cincinnati.

A consideration of various pathological conditions involving the central nervous system having relationships to the eye. The study is based on material collected at autopsy chiefly from the Cincinnati General Hospital and is illustrated with lantern slides.

Discussion—D. J. Lyle, Cincinnati, and A. D. Ruedemann, Cleveland.

Second Session

Wednesday, May 4, 9:00 A. M.
Meeting Place—Roof Garden, Miami Hotel.

2. PRACTICAL CONSIDERATIONS OF SPHENOIDAL SINUS INFECTION—by Harris H. Vail, Cincinnati.

In this paper the disease entities which strongly suggest a sphenoid sinus infection are discussed; namely, retrobulbar optic neuritis, vidian neuralgia, hay fever and asthma. The new methods of diagnosis of sphenoid sinus disease together with the treatment are considered. The paper will be supplemented with lantern slides of actual cases and this, together with a few illustrative case reports, should emphasize the importance of the sphenoid sinus in many diseased conditions. Lantern slides.

Discussion—Wm. Mithoefer, Cincinnati, and Edward D. King, Cincinnati.

3. CERVICAL TYPE OF LYMPHADENOPATHIES—by B. K. Wiseman, Columbus.

Although there are a great many pathologic types of lymph node diseases, for practical purposes all these can be grouped into a relatively small number of clinical types. Many of the latter can be accurately identified by clinical examination, but recourse to biopsy is often necessary. Chief differential diagnostic criteria and therapeusis of the more important types will be emphasized.

Discussion—Hugh G. Beatty, Columbus, and Russell G. Means, Columbus.

4. SUBDURAL ABSCESS: ITS RELATION TO STERLE PURULENT LEPTOMENINGITIS — by W. James Gardner, Cleveland.

The two cases herein reported are of interest in that they demonstrate the effectiveness of the arachnoid membrane as a barrier against infecting organisms. The sequence of events in the two cases as reconstructed from the history and operative findings was otitis media, infective pachymeningitis interna, sterile purulent leptomeningitis and subdural abscess. Recovery occurred in the case in which two subdural abscesses were drained 33 days and 63 days, respectively, after the onset of cerebral symptoms. Death occurred in the other case in which a single subdural abscess drained eight days after the onset of cerebral symptoms. Lantern slides.

Discussion—Henry M. Goodyear, Cincinnati, and George L. King, Jr., Alliance.

5. THE RELATIONSHIP BETWEEN INFECTIONS OF THE UPPER RESPIRATORY TRACT AND PEDIATRIC CONDITIONS FROM THE LARYNGOLOGICAL VIEWPOINT—by L. W. Dean, Washington University School of Medicine, St. Louis, Missouri.

The fundamentals of nasal sinus disease in young children.

Laboratory methods of diagnosis.

The influence of certain systemic conditions on the production of sinusitis.

The benefits to be derived by the eradication of sinusitis in certain pediatric conditions.

Discussion—Sterling H. Ashmun, Dayton, and John E. Brown, Columbus.

NERVOUS AND MENTAL DISEASES

JOHN D. O'BRIEN, Canton ..... Chairman
J. FREMONT BATEMAN, Cincinnati ..... Secretary

First Session

Tuesday, May 3, 2:00 P. M.
Meeting Place—Room 412, northwest corner, Dayton-Biltmore Hotel.

1. GRAPHIC METHODS OF EVALUATING REMISSIONS IN GENERAL PARALYSIS—by Richard E. Stout, Cleveland, by invitation.

Earlier diagnosis and treatment of general paralytics makes it advisable to adopt additional standards of determining the degree of remissions due to malarial therapy. The effect of therapeutic malaria on the tremor, handwriting, and dysarthria of general paraytics is studied. A practical method of graphically recording the tremor of general paralytics and its rate and degree of improvement following malarial therapy is presented. This improvement or lack of improvement is correlated with the change in the mental and emotional status of the patients. Lantern slides.

Discussion—O. O. Fordyce, Toledo, and A. T. Steegmann, Cleveland.

2. BROMIDE AS A CAUSE OF PSYCHOSES—by G. T. Harding, Jr., Columbus.

Excess of bromides in the body is a frequent cause of a toxic psychosis. Signs and symptoms of such an organic involvement of the nervous system are set forth so that a careful clinical observer may do more than merely suspect that his patient—"does not do well on the bromides." Recent illuminating medical literature is referred to.

The value of Wuth's comparator test as a practical method of estimating the blood bromide is emphasized. Identification of this toxic factor may help to differentiate certain cases from the other serious brain diseases and favorably modify the prognosis in conditions which it complicates. Recognition of the condition promotes more effectual treatment. Brief resume of a number of cases will be given.

Discussion—C. E. Kiely, Cincinnati, and D. A. Johnston, Cincinnati.

3. THE DEHYDRATION TREATMENT OF EPILEPSY—by H. C. Stevens, Cleveland.

The role of water metabolism in the causation of convulsive seizures is explained. The secretion and circulation of the cerebro-spinal fluid is outlined and its bearing on epilepsy is elucidated. The dehydration treatment is described and the results obtained are presented. Lantern slides.

Discussion—E. C. Cutler, Cleveland, and S. L. Bossard, Gallipolis.

4. A PRACTICAL PROGRAM FOR A STATE MENTAL HYGIENE ASSOCIATION—by Henry C. Schumacher, Cleveland.

The purpose of this paper is to outline a practical statewide program in mental hygiene. The defeat of the $7,500,000 state welfare bond issue is sufficient evidence that there is a woeful lack in understanding of the needs in the field of mental disease and defect as well as in the field of mental hygiene. Failure to foster and to exercise certain control of a mental hygiene program is bound to turn this movement over to lay people with subsequent dangers of charlatanry. Such dangers are real, not imaginary, as witness the activities of so-called psychoclinicians and consulting psychologists and lay psychoanalysts.

Discussion—E. A. North, Cincinnati, and T. A. Ratcliff, Cincinnati.

Second Session

Wednesday, May 4, 9:00 A. M.

Meeting Place—Room 412, northwest corner, Dayton-Biltmore Hotel.

5. THE NEUROLOGICAL ASPECTS OF INDUSTRIAL ELECTROCUTION—by Louis J. Karnosh, Cleveland.

The clinical features of minor electrical shock include a localized segmental irritation with neuralgia and hypesthesia, suggesting a radicular syndrome. In several cases the situation is complicated by a pernicious neurosis of a post-traumatic variety.

In a case which survived a severe electrical shock for six months the neuropathological findings are discussed. The perivascular lesions of Spitzka and Radasch are found in the cord and petechial hemorrhages are demonstrated in the medulla. With special stains the intraneural changes are presented and a red-cell satellitosis is seen in the anterior horn region. Lantern slides.

Discussion—Ernest Scott, Columbus, and J. Fremont Bateman, Cincinnati.

6. THE NEWER MEDICAL AND SURGICAL APPROACHES IN THE TREATMENT OF DISEASES OF THE SYMPATHETIC NERVOUS SYSTEM—by E. C. Fischbein, Dayton.

The contact of the neuro-psychiatrist with the neuro-surgeon is becoming even more intimate than it has been in the past, because of the remarkable effects of ganglionectomy in such diseases as angina pectoris, scleroderma, and Raynaud's disease the peculiar effect of excision of the pre-sacral nerve in cord bladder; the remarkable effect of suprarenal neurectomy in essential hypertension, and the encouraging results in stimulation of both the bulbo-sacral and sympathetic components of the autonomic nervous system in the pseudo-hypertrophic type of chronic progressive muscular dystrophy. These measures give augury of a new era in the attack on these little understood diseases. Lantern slides and motion picture illustrations of these effects will be shown.

Discussion—Roy D. Arn, Springfield, and Mont R. Reid, Cincinnati.

7. REPORT OF A CASE OF THE REMOVAL OF THE RIGHT CEREBRAL HEMISPHERE—by John D. O'Brien, Canton.

A woman, thirty-one years of age, who began to have generalized convulsions ten years ago. Recently had Jacksonian convulsions on the left side of the face and head. A mild left hemiparesis, with left homonymous hemianopsia, with choking of the discs; loss of sensation of position of the left arm and leg; osterognosis of the left hand.

Clinical Diagnosis: Right Parietal Lobe Tumor.

Removal of the right cerebral hemisphere for infiltrating glioma on August 31, 1931. Present condition of the patient, with moving pictures.

Discussion—W. James Gardner, Cleveland, and John A. Caldwell, Cincinnati.

8. LATE EFFECTS OF ENCEPHALITIS IN YOUNG CHILDREN—by H. D. McIntyre, Cincinnati.

Of late years many cases of encephalitis accompanying infectious diseases of childhood have been reported. Discussion of the symptomatology of these conditions follows together with illustrative case reports.

Discussion—Louis A. Lurie, Cincinnati, and F. C. Wagenhals, Columbus.

PUBLIC HEALTH AND INDUSTRIAL MEDICINE

RUDOLPH C. ENGEL, Cleveland ..... Chairman
R. H. MARKWITH, Akron ..... Secretary

First Session

Tuesday, May 3, 2:00 P. M.

Meeting Place—Parlors, northwest corner mezzanine floor, Dayton-Biltmore Hotel.

1. THE DETERMINATION OF VISUAL ACUITY—by Paul G. Moore, Cleveland.

Though the determination of the visual acuity is apparently a simple matter and the methods used are not complicated, they are frequently misunderstood and the results of the examination inaccurately stated. There is now a standard method recommended by the American Medical Association and used by the Industrial Commission of Ohio which, if adopted by each examiner, would result in uniform measurements of visual acuity.

Some examiners still persist in measuring visual acuity by former methods causing confusion in estimating loss of visual acuity. Employers of large numbers of workmen will protect themselves and their employers by making records of the visual acuity at the time of employment. The estimation of the visual acuity in unco-operative cases. Lantern slides.

Discussion—Albert D. Frost, Columbus, and George Sykes, Cleveland.

2. RECENT ADVANCES IN TULAREMIA—by Walter M. Simpson, Dayton.

Tularemia probably occupies a unique position in medical history because of the rapidity with which it has evolved from the obscurity of a clinical curiosity to the prominence of an important public health problem. Six years ago tularemia was practically an unknown name in medical literature; reports of about fifteen cases had appeared up to that time. Tularemia has now been recognized in all but five of the states in the Union. The recognition of the widespread incidence of the disease in Soviet Russia, Japan, and Norway indicates that the disease is probably worldwide in its distribution. While wild rabbits constitute

the most important reservoir of infection for other wild animals and man, new animal hosts and insect vectors have been discovered. This paper will be based upon a summary of recent investigations and a consideration of the Dayton experience with ninety-eight cases. Lantern slides.

Discussion—Leo F. Ey, Columbus, and E. E. Campbell, Columbus.

3. SOME PRESENT DAY IDEAS CONCERNING HEART DISEASE, FROM THE PUBLIC HEALTH POINT OF VIEW—by Julien E. Benjamin, Cincinnati.

Many of the present day advices concerning prevention of heart disease are probably impracticable and unsound. Since deaths due to rheumatism before forty years, have shown a substantial decline as against the sharp rise in the rate due to heart disease after forty, it is necessary to consider certain functional factors such as proper methods of living and working, emotional instability, etc.

The results of the examination of three thousand apparently healthly individuals in industries to be reported on, as well as the importance of periodic health examinations. Lantern slides.

Discussion—Floyd P. Allen, Cincinnati, and Harold Feil, Cleveland.

4. ADULT HEALTH EDUCATION—by Robert Lockhart, Cleveland.

The duty of the individual physician in health education. The duty of the medical society in health education. The duty of the board of health in health education. The duty of the local communities in health education. The duty of all educated people in health education.

Discussion—J. J. Sutter, Lima, and G. T. Wasson, Bucyrus.

Second Session

Wednesday, May 4, 9:00 A. M.

Meeting Place—Parlors, northwest corner, mezzanine floor, Dayton-Biltmore Hotel.

5. OCCUPATIONAL SKIN DISEASES: DERMATOLOGIC HINTS FOR THEIR ELIMINATION. (With demonstration)—by Karl G. Zwick, Cincinnati.

While the so-called "dermatergoses" have always existed, only with the growing industrialization have they become so widely disseminated throughout the population, that their prevention has become a serious problem in certain industries.

Knowledge of causes is indispensable for the success of prophylaxis. Grouping of causes under the two heads of A *predisposing*, and B *exciting* factors is both comprehensive and convenient.

A. Investigation of the existence of a *predisposition* to dermatoses is particularly the function of the *pre*liminary *pre*-employment examination of an applicant.

B. The investigation into *exciting* causes is facilitated, in a given case, by the dermatologists' analytical and synthetical method of *biologic skin-probes*.

Familiarity with the *pathogenic mechanism of occupational dermatoses* aids us in: 1, the interpretation of the results of the biologic method; 2, the comprehension of its limitations; 3, the application to preventive practice. Case reports. Lantern slides.

Discussion—Clyde L. Cummer, Cleveland, and Sidney Littman, Cleveland.

6. THE HOSPITAL HEALTH SERVICE OF THE NURSE IN TRAINING—by Willard C. Stoner, Cleveland.

General considerations of health service. The importance of health examination in selecting the candidate for nurse training. The importance of yearly health examinations. The importance of daily sick call at a fixed time, conducted preferably by the medical resident. The importance of early hospitalization for all illnesses.

The importance of immunization against diphtheria, scarlatina and smallpox. The tonsil problem in relation to throat infections; such as, tonsillitis, Vincent's angina, scarlatina and diphtheria. Diseases that are largely responsible for hospitalization. The problem of tuberculosis in the nurse that is in training. Blank forms for hospitalization and for sick call. Importance of early isolation of all acute infections to prevent dissemination such as throat infections that may be an early sign of scarlatina, etc.

Discussion—Lee H. Ferguson, Cleveland, and J. A. Toomey, Cleveland.

7. THE ESTIMATION OF DISABILITY FROM AN ORTHOPAEDIC STANDPOINT—by Walter G. Stern, Cleveland.

The amount of permanent disability remaining (after the acute stage and the temporary disability is over) can only be estimated empirically from our knowledge as to what other persons with similar disabilities have been able to do.

As an example it has been found that the amputation at the hip joint, while it is a 100 per cent total loss of limb, is only a 50 per cent total permanent loss in earning power (in moderately young people). Lantern slides.

Discussion—H. H. Dorr, Columbus, and B. J. Hein, Toledo.

8. DISCUSSION OF INDUSTRIAL MEDICINE—by D. B. Lowe, Akron.

Much has been written about industrial medicine and the physician in industry, its fundamentals and his qualifications. This paper proposes to discuss some of the practical considerations of the subject.

Discussion—Emery R. Hayhurst, Columbus, and A. G. Cranch, Cleveland.

EASTERN STANDARD TIME

The time indicated on this program is Eastern Standard Time.

ESSAYISTS-DISCUSSANTS

"All papers read before this Association shall be its property. Each paper shall be deposited with the Section Secretary when read. Authors shall not cause papers read before this Association to be published as original elsewhere, nor until after they have been published in the official *Journal* of this Association."—Chapter IV, Section 3, By-Laws.

Discussants of papers are requested to forward typewritten copies of their remarks to the *Ohio State Medical Journal*, 131 East State Street, Columbus, Ohio, not later than two weeks after the Annual Meeting in order that they may be published with the papers.

REGISTRATION

General Registration for all members and guests will be conducted at the Registration Headquarters which will be located at the entrance to the Exhibit Hall immediately to the south of the main lobby on the main floor of the Dayton-Biltmore Hotel, the headquarters hotel.

Admission to all sections and general meetings, and to the special entertainments in connection with the meeting will be by badge only. Everyone in attendance must register.

Chapter 1, Sections 1, 2 and 3, of the By-Laws restricts registration and attendance at the annual meeting and its various sessions to members of the Association in good standing. Physicians from outside Ohio, medical students and eminent members of scientific professions not medical but allied thereto, may be admitted as guests at the annual meeting.

Be sure to take your 1932 membership card to Dayton with you as its presentation at the Registration Headquarters will greatly facilitate the registering of members.

Special Entertainment Features at Forthcoming Annual Meeting ⸗⸗⸗ Excellent Scientific Exhibit Arranged ⸗⸗⸗ Clinics at Hospitals Scheduled

SCIENTIFIC EXHIBIT

One of the principal attractions of the Dayton meeting will be the Scientific Exhibit which has been arranged by a committee consisting of Dr. Walter M. Simpson, chairman, assisted by Dr. Foy C. Payne.

The Scientific Exhibit will occupy a space at the west side and in the southwest corner of the spacious hall immediately to the south of the main lobby on the main floor of the Dayton-Biltmore Hotel in which the commercial exhibits and registration headquarters also will be located.

Every member of the State Association who is privileged to attend the Dayton meeting undoubtedly will be tremendously interested in the splendid demonstrations which have been arranged by Dr. Simpson and Dr. Payne. For the past few years, the Scientific Exhibit held in connection with the Annual Meeting of the American Medical Association has been one of the principal features of those gatherings. A number of Ohio physicians who have helped to make the A. M. A. exhibit of great value to those in attendance at A. M. A. meetings, have submitted exhibits in the Dayton demonstration, along with other Ohio physicians who have been making interesting and valuable research studies on a wide variety of subjects. The exhibit promises to be a feature which none in attendance can afford to miss.

The following Scientific Exhibits will be presented:

Roentgenological Diagnosis of Cardiac Lesions. David Steel, Lakeside Hospital, Cleveland. This demonstration will consist of reduced teleoroentgenograms of pathological hearts which have been studied fluoroscopically and the findings proved at postmortem examination. The cardiac silhouette is correlated with the anatomical specimen.

The Friedman Test for Pregnanc. Ernest Scott, H. L. Reinhart and Tom F. Lewis, Ohio State University, Columbus. This exhibit will consist of illustrative charts, mounted specimens, animal demonstrations and a motion picture film of the technique of operation.

The Pathology of the Heart. Ernest Scott and H. B. Davidson, Ohio State University, Columbus. This exhibit will consist of mounted specimens illustrating various pathological changes of the heart accompanied by photomicrographs.

X-ray Studies of Some Orthopedic Lesions. Joseph A. Freiberg and Samuel Brown, Cincinnati. Special attention will be given to hip-joint lesions and to benign neoplasms of bone. Some unusual osseous lesions and operative bone cases will be included.

Observations on the Etiology, Prevention and Cure of Rickets and Rachitic Spasmophilia. H. J. Gerstenberger, J. I. Hartman, J. D. Nourse, G. R. Russell, A. J. Horesh, D. N. Smith, D. G. Shields, Babies' and Children's Hospital, Cleveland. The object of this exhibit is to present first-hand evidence of the work done in the Babies' and Children's Hospital of Cleveland, in connection with the etiology, prevention and treatment of rickets and of rachitic spasmophilia. The exhibit presents copies of full-sized roentgenograms and photographic positives of schematic charts which present graphically the various clinical and laboratory data pertinent to the subject matter.

X-ray Studies of the Neck, Bronchi and Esophagus. Samuel Iglauer and Samuel Brown, University of Cincinnati, Cincinnati. This exhibit consists of *X*-ray films illustrating various lesions of the neck, bronchi, and esophagus. These include retropharyngeal abscess and tumors, carcinoma of the root of the tongue, laryngeal lesions, thyroid tumors, tracheal disorders, esophageal and bronchial lesions, foreign bodies, and retro-esophageal mediastinitis.

Studies of the Physiology of the Male Sex Hormone with Especial Reference to Prostatic Hypertrophy. William E. Lower, N. F. Hicken, W. K. Cuyler, Cleveland Clinic Foundation Research Department, Cleveland. This exhibit will consist of photographs and cages of caponized chickens and parabiotic rats, illustrating studies of the physiology of the male sex hormone.

Neuro-Surgical Technique. William James Gardner, Cleveland Clinic, Cleveland. This exhibit will consist of 100 8 x 10 photographs of neuro-surgical procedures made at the operating table.

ANNUAL BANQUET

Tuesday, May 3, 1932
Dayton-Biltmore Hotel

The Entertainment Committee of the Montgomery County Medical Society has completed plans for the Banquet, at the annual meeting of the State Association, which will be held at the Dayton-Biltmore Hotel, Tuesday evening, May 3, when the addresses of the President, Dr. D. C. Houser, Urbana, and the President-elect, Dr. H. M. Platter, Columbus, will be presented.

Dr. Charles H. Tate, Dayton, chairman of the Entertainment Committee, will preside as toastmaster.

Following the addresses of the President and President-elect, the diners will be addressed by John B. Kennedy, a Collier's editor and famous radio broadcaster on the Collier's Hour, who will

speak on "Civics for Civilized Men". Mr. Kennedy is a public speaker of nation-wide reputation and a keen observer of economic, social and political events and developments.

Special entertainment will be provided while the banquet is being served and following the program which will be concluded by the presentation of the President's gavel to the retiring President, Dr. Houser.

An informal reception for the retiring president and incoming president and dancing will follow the banquet and the addresses.

Other members of the Dayton Entertainment Committee are: Drs. B. W. Beatty, R. A. Lewis, Sterling H. Ashmun and Mack Shafer. The committee has arranged for space near the Registration Headquarters where tickets for the banquet may be obtained by visiting physicians.

ORGANIZATION LUNCHEON

Tuesday, May 3, 1932

Hotel Gibbons

On Tuesday noon, May 3, at the Hotel Gibbons, will be held the usual Organization Luncheon at which the presidents, secretaries, treasurers, legislative and medical defense committeemen of the component county societies and academies of medicine, and the state officers and district councilors will be the guests of the State Association.

It will be noted that this year the Organization Luncheon will be held on the first day of the annual meeting, instead of on the second day as customary. Because the Program Committee found it necessary to schedule the General Scientific Session on Wednesday afternoon, May 4, to start at 1 o'clock, instead of 1:30 o'clock as customary, it was decided to hold the Organization Luncheon on Tuesday noon, May 3, in order to avoid any conflict in time and to provide more time for the luncheon and brief program which will follow. The luncheon will follow the first session of the House of Delegates and will be over in plenty of time for all in attendance to be present at the first session of the several Scientific Sections, starting at 2 p. m.

The program which will follow the Organization Luncheon will consist in general of a discussion of organization matters and activities, led by Dr. D. C. Houser, the president; Dr. H. M. Platter, the president-elect; Dr. John B. Alcorn, chairman of the Committee on Public Policy, and Dr. J. E. Tuckerman, chairman of the Committee on Medical Defense. Admission by special card.

CLINICS

A program of medical and surgical clinics is being arranged by the Montgomery County Medical Society as an additional feature in connection with the Annual Meeting.

Members who arrive in Dayton on Monday, May 2, will no doubt want to attend several of the demonstrations which will be given at a number of Dayton hospitals.

The tentative preliminary schedule for the clinics is as follows:

Monday, May 2, 9 to 11 a. m., *Dayton State Hospital.* Clinic on mental cases by the staff, with Dr. E. L. Hooper, superintendent, in charge.

Monday, May 2, 9 to 11 a. m., *National Military Home.* Medical and surgical clinics. Colonel Vernon E. Roberts, chief surgeon, in charge.

Monday, May 2, 1:30 to 3:00 p. m., *National Military Home.* Dry and operative clinics and G. U. clinic.

Monday, May 2, 1 to 4 p. m., *National Military Home.* Eye, ear, nose and throat clinic.

Monday, May 2, 9 to 12 a. m., *Miami Valley Hospital.* Surgical, dry and operative, medical, G. U. and orthopedic clinics. Dr. Harry R. Huston in charge.

Monday, May 2, 9 to 12 a. m., *St. Elizabeth Hospital.* Surgical, dry and operative, medical, G. U. and orthopedic clinics. Dr. Curtiss Ginn in charge.

Post Graduate Day at Youngstown, April 28

Fifth Annual Post-Graduate Day sponsored by the Mahoning County Medical Society will be held April 28 at the Hotel Ohio, Youngstown, and the Youngstown Club.

The morning and afternoon sessions will be held at the hotel and the dinner and evening sessions at the Youngstown Club.

The program will be presented by a group from the staff of the Peter Bent Brigham Hospital, Boston.

Tentatively, the program for the all-day event is as follows:

9 a. m., Dr. Henry A. Christian, "Varieties of Bright's Disease and Their Management".

10 a. m., Dr. Samuel A. Levine, "A Clinical Conception of Rheumatic Heart Disease".

11 a. m., Dr. William C. Quinby," Cardio-Renal Balance After Operations".

1 p. m., Dr. Merrill C. Sosman, "Through the Alimentary Canal with the Fluoroscope".

2 p. m., Dr. Samuel A. Levine, "The Bedside Recognition and Treatment of Cardiac Irregularities".

3 p. m., Dr. William C. Quinby, "Some Clinical Aspects of Urinary Calculi and Their Treatment".

4 p. m., Dr. Henry A. Christian, "Diuretics and Their Uses".

6 p. m., Dinner, to be followed by a clinico-roentgenological conference by the visiting physicians.

The committee in charge of arrangements for the event is composed of: Dr. Paul J. Fuzy, chairman, Dr. G. G. Nelson, vice chairman, Dr. J. D. Brown, Dr. R. B. Poling, Dr. Julia March Baird, Dr. Louisa S. Cervone, Dr. W. X. Taylor, and Dr. W. H. Bachman.

Reduced Railway Fares Have Been Secured For Those Attending the Annual Meeting in Dayton in May

Arrangements have been made for special reduced steam railway fares for members of the Ohio State Medical Association and dependent members of their families who attend the Eighty-Sixth Annual Meeting of the State Association in Dayton, May 3 and 4, providing certain definite requirements promulgated by the Central Passenger Association are met.

The reduced fare "certificate" plan arranged for is practically the same as the fare reduction plans which have been used at several previous annual meetings of the State Association with the exception that the necessary minimum of members who must take advantage of the plan before the fare concession will be made has been reduced to 100.

On one or two occasions, this minimum was considerably higher and was not obtained, which nullified the concession for all. However, with the minimum reduced to 100, it is quite probable that all who attend the Dayton meeting by train will have an opportunity to save on the cost of transportation.

Members who take advantage of this reduced fare proposition will be able to make the trip to Dayton and return at a cost three-fourths of the regular round-trip rate, providing all the requirements governing the plan are met.

Tickets to Dayton under the plan may be purchased as early as April 29 and as late as May 4, the final day of the annual meeting, and tickets for the return trip as late as May 7. Persons purchasing tickets from points outside of Ohio will not be granted the reduced rate.

In order that all members of the State Association will know exactly how to proceed, the following directions and explanations given by Chairman C. A. Fox, of the Central Passenger Association, Chicago, should be followed:

1. Tickets at the regular one-way tariff fare for the going journey (to Dayton) should be obtained on any of the following dates (but not before or after), April 29 to May 4, inclusive.

2. When purchasing this ticket at your home station, *be sure you request a "Certificate". Don't make the mistake of asking for a "receipt".*

3. Present yourself at the railroad station for the ticket and certificate at least 30 minutes before the departure of the train on which you plan to make the journey to Dayton.

4. Certificates are not kept at all stations. It is suggested that you inquire at your home station and ascertain whether or not the agent can issue a through ticket and certificate to Dayton. If not, the agent will inform you of the nearest station at which they can be obtained. In such case, you should purchase a local ticket to the station which has certificates in stock and from there buy a through ticket to Dayton, and at the same time ask for and secure, a "Certificate Plan" cetrificate.

5. Certificates can not be issued unless the regular one-way tariff fare for the journey to Dayton is 67 cents or more.

6. *As soon as possible after your arrival in Dayton,* register for the Annual Meeting at the Registration Headquarters at the Dayton-Biltmore Hotel where you should *present your "certificate"* to an endorsing officer who will be authorized to vise your "certificate". Reduced fare for the return journey will not apply unless you comply with these directions. Your membership card and badge (secured at registration) will serve as your identification for this purpose.

7. Arrangements have been made for the validation of certificates by a special agent of the carriers on May 3 and 4 provided the required minimum of 100 certificates is presented.

8. No refund of fare will be made because of failure to obtain a proper certificate when purchasing ticket or on account of failure to have the certificate validated.

9. If the necessary minimum of 100 certificates is presented at the meeting and your certificate is duly validated by the special agent, you will be entitled, up to and including May 7, to purchase at Dayton a return ticket via the same route over which you made the journey to Dayton at one-half of the regular one-way tariff fare from Dayton to the point at which your certificate was issued.

10. To prevent disappointment, it should be understood that the reduction on the return journey is not guaranteed, but is contingent on an attendance at the meeting of not less than 100 members of the State Association and dependent members of their families, holding regularly issued certificates obtained from ticket agents at starting points, each showing the payment of regular one-way adult tariff fare of 67 cents or more on the going journey.

—The city of Berea has signed a contract with the Cuyahoga County Board of Health for health service to be furnished by the Cuyahoga board.

—Dr. Oscar M. Craven has been named health commissioner of Springfield, succeeding Dr. Howard C. Lisle.

—Dr. W. E. DeCrow, former health commissioner of Scioto County, has been appointed a medical inspector in the Division of Communicable Diseases, State Department of Health.

—Dr. J. D. Francis, Haydenville, has been named a member of the Hocking County Board of Health.

Those Who Expect to Attend the Annual Meeting in Dayton Should Make Hotel Reservations Now

Members of the State Association expecting to attend the Eighty-Sixth Annual Meeting, Tuesday and Wednesday, May 3 and 4, at Dayton, who have not as yet secured hotel reservations during the time of the meeting are urged to do so immediately.

Requests for hotel accommodations should be made directly to the hotel selected and verification should be requested.

Most of the sessions of the annual meeting will be held at the Dayton-Biltmore Hotel, the headquarters hotel. It also will house the commercial and scientific exhibits, and the registration headquarters. Sessions not held at the Biltmore will be held at the Miami Hotel, a short distance from the Biltmore.

For the convenience and information of members who have not as yet made hotel reservations, *The Journal* is republishing the list of Dayton hotels, with their rates and conveniences, which was carried on page 198 of the March, 1932, issue. The list is as follows:

DAYTON-BILTMORE

Headquarters Hotel

Corner of First and Main Streets, 600 rooms; single room, lavoratory and toilet, $2.50; single room, with bath, $3.00 up; single room, combination tub and shower, $3.50, $4.00 and $5.00; double room, with bath, $5.00; double room, combination tub and shower, $6.00, $7.00, $8.00 and $9.00; suites, $9.00 up; double rooms occupied by three persons $2.00 additional; garage adjoining hotel.

MIAMI HOTEL

Second and Ludlow Streets, (where some of the section sessions will be held), 350 rooms; single room with bath, $3.00 up; double room with shower, $5.00 up; double room with tub bath, $5.00 up; room with twin beds, $6.00 up; suite, $15.00 up.

VAN CLEVE HOTEL

First and Ludlow Streets, 150 rooms; single room with bath, $3.00 up; double room with shower, $5.00 up; double room with tub bath, $5.00 up; room with twin beds, $6.00; suite, $15.00.

GIBBONS HOTEL

Third and Ludlow Streets, 250 rooms; single room with bath, $2.50; double room with shower, $5.00 up; double room with tub bath, $5.00; room with twin beds, $4.00; suite, $6.00 up; single room with tub and shower, $3.00; double room, tub and shower, $5.00.

MORAINE HOTEL

Ludlow near Third, 150 rooms; single room with bath, $2.50; room with twin beds, $3.00; suite, $7.00.

Beckel Hotel

Third and Jefferson Streets, 300 rooms; single room with bath, $2.00 up; double room with tub bath, $2.50 up; room with twin beds, $1.50 up; suite, $5.00.

Colonial Hotel

Fifth near Wilkinson, 100 rooms; double room with tub bath, $3.50; room with twin beds, $3.50; suite, $5.00; single room without bath, $1.50 up; double room without bath, $3.00.

Holden Hotel

Fifth and Wilkinson Streets, 100 rooms; single room with bath, $2.50; single room without bath, $1.75; single room tub and shower bath, $3.00; double room with shower bath, $4.50; double room, tub and shower bath, $5.00; room with twin beds, $5.00.

Haynes Hotel

Third and Ludlow Streets, 50 rooms; single room with bath, $2.00 up; double room with tub bath, $3.50 up; room with twin beds, $3.00.

Ohio Hotel

Fifth near Wilkinson, 35 rooms; single room with bath, $2.00; double room with tub bath, $3.00; room with twin beds, $3.00.

—During 1931, diarrhea and enteritis in children under two years of age claimed 697 lives, the lowest number ever recorded in the state, but representing 571 more deaths than those from whooping cough in all ages; 570 more than the deaths from diphtheria; 569 more than the deaths from typhoid fever; 560 more than the deaths from measles, and 513 more than the deaths from scarlet fever. This cause is reportable under the regulations of the State Health Department, but the Department reports that during the past 10 years there are 24 counties in the state which have failed to report a single case of diarrhea and enteritis.

Sixty-first annual meeting of the American Public Health Association will be held in Washington, D. C., October 24-27, with the Willard as the headquarters hotel.

Policies, Program, Publication Problems, Constitutions and Other Important Matters Acted on by Council at March Meeting

The Council of the Ohio State Medical Association met in the headquarters office, Columbus, at 1:00 P. M., on Sunday, March 6, 1932.

The Officers and Councilors present were: President, Dr. D. C. Houser; President-Elect, Dr. H. M. Platter; Ex-President, Dr. C. W. Waggoner; Treasurer, Dr. James A. Beer; Councilors, Dr. J. A. Caldwell, Dr. E. M. Huston, Dr. O. P. Klotz, Dr. B. J. Hein, Dr. C. L. Cummer, Dr. H. S. Davidson, Dr. E. B. Shanley, Dr. I. P. Seiler, Dr. S. J. Goodman; Dr. J. B. Alcorn, Chairman, and Dr. J. H. J. Upham, member, Policy Committee; and Executive Secretary Martin, and Assistant Executive Secretary Nelson.

The minutes of the Council meeting held on December 13, 1931 (published on pages 55 to 59 inclusive of the January, 1932 issue of *The Journal*) were read, and on *motion* by Dr. Davidson, seconded by Dr. Klotz and *carried*, were *approved*.

With appropriate words of commendation, President Houser presented to Dr. C. W. Waggoner, the last-retiring President, the official past President's gavel, which was accepted with appropriate words of appreciation.

PROGRAM FOR 1932 ANNUAL MEETING

Dr. Platter, Chairman, and Dr. Goodman, Secretary of the Council Program Committee reported in detail on the scientific program, as arranged for the forthcoming annual meeting and submitted for the consideration of the Council, which had been sent previously to each member of Council in proof form. Program was considered item by item.

Upon *motion* by Dr. Davidson, seconded by Dr. Waggoner and *carried*, the Council decided to adhere to precedent and ruled that the name of no member could appear on any Section program more than once, either as an essayist or a discussant. It was explained, however, that this ruling would not prevent such discussants, or others not scheduled on the program, from participating in the general discussion on any or all papers.

Upon *motion* by Dr. Seiler, seconded by Dr. Davidson and *carried*, the Council instructed the Secretary to communicate with those members scheduled on the program whose 1932 dues in the State Association have not yet been received, pointing out the Constitutional requirement for continuous membership in order to be privileged to attend the annual meeting and participate in the program.

With certain detailed changes and corrections in the program, by the *motion* of Dr. Cummer, seconded by Dr. Klotz and *carried*, the Council officially approved the program (published in detail elsewhere in this issue of *The Journal*).

Dr. Huston, Chairman of the Council Committee on Arrangements, reported in detail on the progress and activity by various local committees. He stated that the Local Entertainment Committee, upon a majority vote of the Montgomery County Medical Society, had decided to arrange the banquet for Tuesday evening, May 3, at which time the annual addresses of the President and President-Elect are to be presented, and for which occasion John B. Kennedy of Collier's, well known and popular broadcaster on "Collier's Hour", had been secured as a speaker on the subject of "Civics for Civilized Men".

Dr. Huston also reported on other details and stated that such details would be forwarded to the headquarters office promptly, including the name of the hotel selected for the organization luncheon on Tuesday noon, May 3.

CONSTITUTIONAL QUESTIONS

Dr. Cummer, Chairman of the Council Committee on Constitutional Conformity, reported on the deliberations and action by his Committee since the last Council meeting.

On behalf of his Committee, Dr. Cummer submitted for consideration, with recommendation for approval, the Constitutions and By-Laws of the following component county medical societies:

Adams County Medical Society
Brown County Medical Society
Hardin County Medical Society
Highland County Medical Society
Holmes County Medical Society
Lawrence County Medical Society
Pickaway County Medical Society
Sandusky County Medical Society
Williams County Medical Society.

On *motion* by Dr. Seiler, seconded by Dr. Klotz and *carried*, recommendations of the Committee were adopted, and the Constitutions and By-Laws of the foregoing societies officially approved.

Dr. Cummer recommended the final approval of the Constitutions and By-Laws of the following component societies (previously conditionally approved subject to final completion, and submitted in corrected form since the last Council meeting).

Fairfield County Medical Society
Greene County Medical Society
Academy of Medicine of Toledo and Lucas County
Hempstead (Scioto County) Academy of Medicine.

On *motion* by Dr. Hein, seconded by Dr. Huston and *carried*, the Council adopted the recommendation of the Committee and officially approved the Constitutions and By-Laws of the foregoing societies.

The Committee, through Dr. Cummer, reported on progress and correspondence with the following component societies, the Constitutions and By-Laws of which had been previously conditionally approved, but not yet finally completed:

Clark County Medical Society
Mahoning County Medical Society.

The Committee's report showed that there are only two counties from which Constitutions have not yet been received, or on which the Council has not yet taken action, either conditionally or otherwise, these counties being Monroe and Noble.

The Council expressed appreciation to the Council Committee on Constitutional Conformity for its faithful and effective service.

Attention was called to the several pending amendments to the Constitution and By-Laws of the State Association (as published on pages 199 to 201 inclusive of the March, 1931 issue of *The Journal*). Dr. Cummer discussed especially the proposed amendment No. 1, which he had submitted for action by the House of Delegates at the forthcoming annual meeting, to increase the number of Councilors by the election of four Councilors-at-Large. He stated that he had had considerable correspondence on this question with Councilors and other members, and that in view of the various problems involved, perhaps it would be best to withhold action on this amendment at the next annual meeting, and that it is his present intention to withdraw the amendment when it comes automatically before the House of Delegates, pursuant to its publication and circulation to the county medical societies.

CERTIFICATION OF DELEGATES TO THE A. M. A.

The President, Dr. Houser, submitted for the consideration of Council, correspondence from Dr. Olin West, Secretary of the American Medical Association, in which it was pointed out that under the Constitution and By-Laws of the A. M. A. official certification of delegates must be received at the headquarters office of the A. M. A., for the New Orleans meeting on May 9 to 13, not later than seven days prior to the first meeting of the House of Delegates, or not later than May 2.

In view of the fact that the annual meeting of the State Association will not be held until May 3 and 4, it would be impossible for that provision for election and certification to be complied with, as pointed out by Dr. West, who stated that the committee on credentials of the House of Delegates of the American Medical Association has no alternative because the By-Laws are explicit, and that in the past the committee had been compelled to refuse to seat delegates elected and certified less than seven days prior to the first session.

It was pointed out that under the Constitution and By-Laws of the State Association, the Council may act for the House of Delegates between annual meetings on questions of this nature.

On *motion* by Dr. Davidson, seconded by Dr. Seiler and *carried*, the Council selected and authorized the certification of credentials to the House of Delegates of the American Medical Association for the four delegates and their alternates whose terms expire at the 1932 annual meeting of the State Association. Attention also was called to the certification of the three delegates and alternates whose terms do not expire until the State Association's annual meeting in 1933, all Ohio delegates and alternates being as follows:

Delegates: Dr. Wells Teachnor, Sr., (1932), Dr. Ben R. McClellan, (1932), Dr. E. R. Brush, (1932), Dr. C. W. Stone, (1932), Dr. J. P. DeWitt, (1933), Dr. C. E. Kiely, (1933), and Dr. C. W. Waggoner, (1933).

Alternates: Dr. D. H. Morgan, (1932), Dr. A. C. Messenger, (1932), Dr. C. L. Cummer, (1932), Dr. G. F. Zinninger, (1933), Dr. L. H. Schriver, (1933), and Dr. John Sprague, (1933).

A PUBLICATION PROBLEM

There was submitted for the consideration of the Council, correspondence between the Publication Committee and Dr. Henry Wald Bettmann, Cincinnati, as well as a communication from Dr. Bettman to Dr. Houser, the President, in which latter communication an appeal is made to the Council from the action of the Publication Committee in declining to publish a paper by Dr. Bettmann and Dr. Louis Sommer, presented before the Medical Section of the State Association at the last annual meeting.

Attention was called to the Constitutional duties and authorities of the Publication Committee, which, under Section 3 of Chapter 9 of the By-Laws, is "empowered to curtail, abstract or reject papers and discussions". Attention also was called to the right of members to appeal to the Council.

After a number of motions had been made, withdrawn or tabled, on *motion* by Dr. Platter, seconded by Dr. Huston and *carried*, the records in this matter, including the manuscript of the paper and the entire correspondence, were submitted to the entire Publication Committee for consideration by each member of the Committee, and for a report by the Committee in writing at the next Council meeting.

CANCER SOCIETY QUESTIONS

Dr. Platter, Dr. Cummer, Dr. Upham and Dr. Alcorn reported on recent conferences with Dr.

Rector of the American Association for the Control of Cancer, at which times Dr. Rector had solicited the cooperation of medical organization in Ohio in the program of that society and in the selection of an Ohio chairman for the American Society for the Control of Cancer.

It was pointed out by several Councilors that under the terms of a resolution adopted by the House of Delegates of the State Association at the 1930 annual meeting (Resolution A, page 526 of the June, 1930 issue of *The Journal*), the State Association, through its Council, committees, officers, or otherwise, is precluded from designating or recommending "official representatives" of organized medicine to serve in a representative capacity for the medical profession in Ohio in any "outside independent agency, organization or association over which medical organization does not have direct guidance". It was further pointed out that any action in recommending the appointment of a member of the State Association in an official capacity in any other organization, might be construed as an official approval or endorsement of future policies or activities of such separate organization, and that any such contingency would violate the policy already offiically adopted by the House of Delegates.

On *motion* by Dr. Seiler, seconded by Dr. Huston and *carried*, the Council calls attention to the resolution of 1930, to the policies included in it. It was declared, however, that attention should be called to the interest of the State Association in preventive medicine, early diagnosis, periodic health examinations and similar matters, and that the Committee on Periodic Health Examinations should be requested to include in its considerations the early diagnosis of cancer as well as detection of early signs and symptoms in all abnormal pathological conditions.

QUESTIONS OF NATIONAL SCOPE

Dr. Alcorn, Chairman of the Policy Committee, reported somewhat in detail on activities of his Committee recently in observing federal legislation affecting public health and medical service. He outlined the efforts of his Committee in cooperation with the American Medical Association in opposition to a number of paternalistic, subsidy, socialized proposals, among which is an effort to revive federal functions similar to those under the former Sheppard-Towner Act.

Dr. Alcorn and Dr. Upham also reported on the progress of conferences by representatives of the American Medical Association, the American Legion and other organizations on problems in connection with veterans' administration, hospitalization, medical service, etc. Attention was called again to the comprehensive article on this subject authorized by the Committee and published on pages 643 to 646 inclusive of the August, 1931 issue of *The Journal*. It was further indicated that comment and consideration would be given to this question in the forthcoming annual report of the Policy Committee.

Reports were also made on the result of conferences with officials of the Division of Motor Vehicles in relation to physical examinations of applicants for chauffeur licenses. It was pointed out that through cooperation, the procedure had been simplified and due consideration given to freedom of choice by applicants of their physician examiners.

Report was made on possible progress toward an authoritative national survey of osteopathic schools.

Dr. Platter, Dr. Houser and Dr. Upham reported on conferences which had been attended under the auspices of the Ohio Chamber of Commerce as a part of the national campaign on rehabilitation and on anti-hoarding.

Dr. Houser, Dr. Platter and Dr. Upham also reported on the Governor's conference on Child Health and Protection, held in Columbus, January 21 and 22 as a follow-up to the White House conference on the same subject. Attention was called to the subjects discussed on the program and to the individuals in the field of welfare and sociology who had been selected as officers and committees for follow-up work. Attention was called to the article on that conference on page 202 of the March, 1932 issue of *The Journal*.

At this point Dr. Goodman, Secretary, asked to be excused, and the President appointed Dr. Cummer as Secretary Pro-Tem.

MEDICAL LEGAL AND PUBLIC HEALTH PROBLEMS

A report was submitted on recent court decisions in which action had been brought against various corporations, organizations and associations for the unauthorized practice of law. Considerable correspondence on this matter was also submitted for the information of the Council. Several distinctions were pointed out between commercial organizations for profit which are in competition with lawyers, and the incidental legal services rendered to members on a non-commercial, non-professional and non-competitive basis by the State Association.

The President submitted for the information of the Council, recent correspondence from Dr. H. J. Powell, Bowling Green, pertaining to questions of public health administration, preventive medicine and medical organization. Dr. Houser also announced that there probably would be a conference in the near future with Dr. Powell and with Dr. Southard, State Director of Health.

It was pointed out by Dr. Houser that organized medicine, representing the medical profession, is the parent body both in curative and preventive medicine in private practice, and that there should not be, and really is not, any conflict or separation between what might be considered organized medicine and public health. There

are, of course, some functions, such as public education, enforcement of public health and sanitary measures, quarantine, etc., coming within the province of public health administration, which are not within the proper field of private medical practice, but which naturally receive the support and cooperation of the physicians in private practice.

A REQUEST FOR PUBLICATION OF A SERIES OF ARTICLES ON OCCUPATIONAL DISEASES

Dr. Cummer, Secretary Pro-Tem, read correspondence from Dr. Carey P. McCord of Cincinnati, in which the suggestion was made that a series of articles on occupational diseases, be prepared by him and published in *The Journal*, and that these articles be reprinted by the State Association in a booklet for distribution to the members. It was estimated that the cost of space in *The Journal*, the reprints, postage and envelopes would probably be about $650.

On *motion* by Dr. Cummer, seconded by Dr. Platter and *carried*, the Council instructed the Secretary to inform Dr. McCord that the limitations of its budget will not permit the Ohio State Medical Association to print and distribute gratis to the physicians of Ohio, the booklets which he has in contemplation, and that any articles submitted for publication in *The Journal* would be subject to the usual authority and action by the Publication Committee, also with consideration of the limitations of available space.

MEMBERSHIP DATA

Dr. Houser announced that the present membership in the State Association to date for 1932 is 4400 as compared with 4623 on the same date last year, or a net loss at this date of 223; also compared with a total of 5488 at the end of 1930 showing approximately 1088 members in arrears with their 1932 dues. The President emphasized to the Councilors the importance of their efforts in contacting with their component societies in pointing out the importance and necessity of maintaining continuous membership.

WOMAN'S AUXILIARY

Pursuant to the action of the Council at its last meeting in acting on a request from officials of the Woman's Auxiliary, representatives of that organization were invited to be present at this point in the Council session.

Dr. Houser requested Dr. Upham to introduce to the Council the ladies representing the Woman's Auxiliary. These were Mrs. Arthur B. McGlothlan, St. Joseph, Mo., President of the Woman's Auxiliary of the American Medical Association; Mrs. James Edwin Purdy, Canton, President of the Woman's Auxiliary of the Stark County Medical Society; and Mrs. A. A. Ahn, Columbus, state organizer of the national Woman's Auxiliary.

Each of these women spoke on the purposes, programs and activities of a Woman's Auxiliary from the standpoint of national organization, state organization and local organization. Considerable literature had already been submitted to the members of the Council on this matter.

After an hour's hearing and conference, the Council expressed interest in the presentation, and appreciation to the ladies for their presence.

Following the departure of the representatives of the Woman's Auxiliary, on *motion* by Dr. Huston, seconded by Dr. Caldwell and *carried*, the President was requested to appoint a committee of three from the Council to consider the question with reference to previous actions by the Council on this matter since 1924, and to report with recommendations at the next Council meeting. The President announced he would appoint a committee and notify the members he selected.

On *motion*, the Council *adjourned* to meet on Monday evening, May 2, on the eve of the 86th annual meeting of the State Association in Dayton.

S. J. GOODMAN, M.D.,
Secretary of Council.
C. L. CUMMER, M.D.,
Secretary Pro-Tem.

Physicians Must Now Provide Their Own Medicinal Liquor Prescription Forms

Because of the "condition of appropriations" available to the Bureau of Industrial Alcohol, physicians who are licensed to prescribe medicinal liquor will be required to buy their own forms on which to report their prescriptions to the government, according to an announcement recently made by J. M. Doran, U. S. Commissioner of Industrial Alcohol.

The action of the Commissioner in discontinuing the issuance of Form 1402 to physicians has been confirmed by R. E. Joyce, supervisor of permits for District No. 6, Federal Prohibition Department, which includes Ohio.

Mr. Joyce has announced that there still is a small supply of such forms in his office, Enquirer Building, Cincinnati, and that the office will continue to distribute these to permittees upon request until the supply is exhausted.

Supervisor Joyce further announced that as soon as the names of the publishers from whom physicians can obtain books for keeping a record of prescriptions issued have been obtained, a communication listing such companies will be sent to all Ohio physicians holding a permit to prescribe medicinal liquor.

Columbus—Dr. E. D. Helfrich has returned from Miami, Florida, where he spent several weeks this winter.

The President's Page

A Personal Communication to the Membership from

D. C. Houser, M.D., Urbana, Ohio

The primary and fundamental unit of medical organization is, and must continue to be, the county medical society or academy of medicine in each county in the state. Such component societies comprise the Ohio State Medical Association, and the constituent state units comprise the American Medical Association. Such members are eligible to "Fellowship" in our latter national society. This is mentioned to remind you that the basic and most important element in our state and national organization is the county unit.

One or two of the component county medical societies in the state, with but a few members, have considered abandoning their organization and surrendering their charter. I desire to emphasize to all the members, and especially to remind the members in those counties, that such action would strike at the very foundation of medical organization and tend to weaken its present united strength.

Each component county medical society, regardless of how few the number of its members, is entitled to at least one delegate in the House of Delegates of our State Medical Association. The House of Delegates is the legislative and law-making body of our Association, and it is important that your county unit, regardless of how small in numbers, be officially represented. In those societies and academies of medicine where the membership exceeds 100, they are entitled to an additional delegate for each additional 100 members, or fraction, thereof. Moreover, it is important that the county unit be maintained for other purposes, for its contact with local public officials, concerned in any way with public health and medical practice, for each county has its peculiar local problems. Public health, civic welfare, governmental administration and legislation, in addition to scientific programs, are some of the functions that can be carried on effectively only if the unit of medical organization is maintained.

Sometimes it is convenient for a member to join an adjacent county medical society, especially if he lives or practices closer to the county seat or other large center in the adjoining county. Under the Constitution and By-Laws, such affiliation is permissible with the consent of the county society of his residence. However, in those counties which have but few members, each one is needed that much more in order to strengthen the unit of organization. In my visits to many medical societies during the year, I have observed that the percentage of attendance, and perhaps the percentage of interest, is greater in the societies having a smaller membership. This is gratifying and encouraging, and should be continued.

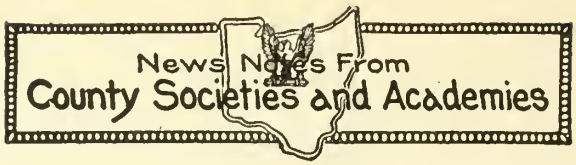
Considerable attention has been directed to the problem of non-resident membership, especially the affiliation by physicians in smaller counties with the larger societies in their districts. Such an arrangement, in case the member maintains his active membership in the county of his residence, may afford him an excellent opportunity to hear scientific programs. However, no such member should neglect his membership, his activity or his interest in his own county society, nor to transfer his *active* membership to the adjoining or larger society; although he may, with propriety, affiliate with the latter through non-resident membership.

Even in those very small societies where it is difficult or even impossible to hold frequent meetings, arrangements should be made to meet as often as possible, and in no case less frequently than once a year, in order to elect officers, delegates, legislative chairman, medical defense committeeman, etc., and in order to maintain county organization and local membership as an effective unit in the State Association.

It is my desire to call your attention to the splendid scientific program prepared for the forthcoming 1932 annual meeting of the State Association in Dayton, May 3 and 4, published elsewhere in this issue. The Program Committee, with fine cooperation from the Section Officers, has given a great deal of careful study to the formulation of this year's program in an effort not only to furnish variety, but to provide an informative and instructive program which will appeal to every member, and especially to those in general practice. This is your meeting. Your should bear in mind the date and make preparation to attend, if at all possible. Also in this issue of *The Journal*, is a list of Dayton hotels with description of facilities and rates. Reservations should be made by you in advance. The many fine highways and the central location of Dayton make it easily accessible from most sections of the state. If, however, it is more convenient, easier or quicker to come by railroad, you will be pleased to learn that arrangements have been made, through the Central Passenger Association, for reduced fares on the steam railroads in Ohio to our annual convention. Detailed announcements on this feature, together with directions for securing "certificates" and validation, appear in this April issue of *The Journal*.

As my conclusion in this brief message, I wish to emphasize to you that now is a time calling for alertness and activity on the part of medical organization. Many perplexing questions affecting our profession must be confronted and, if possible, solved to our satisfaction and in the best interest of the public. Battles are not won by officers in the army. They are won by the fighters, the rank and file—the membership.

The officers and committees of our Ohio State Medical Association have not only planned a great annual meeting for this year, but constructive and consecutive activities on behalf of the entire membership. Their success, which is your success, will depend on your interest and activity in your constructive loyalty and devotion to the cause of organized medicine. You are to be commended for your efforts and sacrifices on behalf of your patients and the public at large. Come to the Dayton meeting prepared to participate in the program. Read this April issue of *The Journal* carefully.



First District

ACADEMY OF MEDICINE OF CINCINNATI

(H. H. Shook, M.D., Secretary)

March 7—General Session. Union Central Building. Program: "Arteriosclerosis, Its Causation and Significance, According to Comparative Anatomy", Dr. Herbert Fox, Philadelphia.

March 14—Medical Section. Union Central Building. Program: "The Presso-Receptory Nerves and Their Functions", Dr. John E. Greiwe. Discussions by Drs. William Muhlberg, Martin H. Fischer, Dennis E. Jackson and Edmund M. Baehr.

March 21—Surgical Section. Union Central Building. Program: "Ancient and Mediaeval Surgical History", (lantern slides), Dr. Carl R. Hiller.

March 28—Specialty Section. Union Central Building. Program: (arranged by the Cincinnati Oto-Laryngological Society) "New Light on Interior Laryngeal Function Through Sound Movies Thereof", G. Oscar Russel, Ph.D., Columbus, director of Phonetics Laboratories, Ohio State University.

Fayette County Medical Society held its regular monthly meeting March 3 at the Washington C. H. Y.M.C.A. The principal address of the evening was made by Dr. V. C. Rowland, Cleveland, on "Periodic Health Examinations". Dr. Rowland, chairman of the Committee on Periodic Health Examinations of the Ohio State Medical Association, also discussed immunization against diphtheria.

At a meeting of the society on February 5 at the Y.M.C.A., the society was addressed by Dr. Wayne Brehm, Columbus.—News Clipping.

Highland County Medical Society held its regular meeting February 10 at the Ballentine Restaurant, Greenfield, with seventeen in attendance. —News Clipping.

Second District

Clark County Medical Society at a luncheon meeting February 10 at the Hotel Shawnee, Springfield, held a symposium on obstetrics. The opening paper in the discussion was read by Dr. Ben R. McClellan, Xenia. Dr. C. S. Ramsey and Dr. R. S. Fidler also read papers on the subject.

At a luncheon meeting of the society on February 24, Dr. C. F. McClintic, professor of neuro-anatomy and neuro-physiology, Detroit College of Medicine and Surgery, addressed the group on "Headaches". Dr. McClintic illustrated his talk with drawings. The subject was discussed by Drs. C. L. Jones, C. L. Minor, I. H. Boesel and J. C. Easton. Members of the Clark County Dental Society were guests of the medical society. About 65 members of the society and guests were present.—Edward C. Nehls, M.D., Secretary.

Darke County Medical Society held a dinner meeting February 12 at the Service Restaurant, Greenville. Dr. D. C. Houser, Urbana, President of the Ohio State Medical Association, was a guest of the society and spoke on organization activities. Scientific papers were presented by Dr. R. K. Finley and Dr. C. J. Mardis, both of Dayton. Both discussed "The Ambulatory Treatment of Varicose Veins and Ulcers", using lantern slides to illustrate their talks.—W. D. Bishop, M.D., Secretary.

Greene County Medical Society held its regular monthly meeting March 4, followed by luncheon at the Iron Lantern, Xenia. Dr. C. S. Ramsey, Springfield, was the guest speaker, discussing "Control of Pain During Parturition". The address was interesting and instructive. The new Constitution and By-Laws of the society was adopted.—H. C. Schick, M.D., Secretary.

Miami County Medical Society met March 4 at the Memorial Hospital, Piqua, Dr. C. A. Coleman, Dayton, read an interesting paper on "Recent Developments in Urology", illustrated with lantern slides. Dinner was served following the program. —G. A. Woodhouse, M.D., Secretary.

Montgomery County Medical Society met in regular session March 18 at the Fidelity Medical Building Auditorium and heard a paper by Dr. C. J. Derby, Dayton, on "Acute Appendicitis". The paper was discussed by Dr. C. C. Payne from the standpoint of children and Dr. Curtiss Ginn from the surgical aspects.

At the meeting of the society on March 4, Dr. V. C. Rowland, Cleveland, addressed the group on "Differential Diagnosis of Chronic Colitis". The society adopted a memorial resolution on the death of Dr. William E. Allaman.—Bulletin.

Preble County Medical Society held its regular monthly meeting February 18 at the Seven Mile Tavern, preceded by a dinner. The principal address of the evening was made by Dr. M. H. Mothersill, Indianapolis, of the medical department of the Eli Lilly Company, who talked on "Some Recent History in the Treatment of

Anemia". A general discussion followed the paper.—News Clipping.

Third District

Auglaize County Medical Society met in regular session February 25 in the Council Chamber of the City Building. The guest speaker was Dr. E. R. Arn, Dayton, who spoke on "Brain Injuries". —News Clipping.

Hancock County Medical Society held its regular monthly meeting March 2 at the Elks' Home, Findlay. Two interesting papers were read by Dr. A. A. Tombaugh, formerly of McComb, now resident physician at the Rocky Glen Sanatorium, one on "Infant Type of Tuberculosis in the Adult", and the second on "Tuberculosis Peritonitis". A round-table discussion concluded the program.—H. O. Crosby, M.D., Secretary.

Marion County—Dr. John D. Hartman and Dr. Frank M. Wiseley, both of Findlay, were the guest speakers at the regular meeting of the Marion Academy of Medicine, held March 1 in the ballroom of the Hotel Harding. The program was preceded by a dinner. The meeting was well attended, the guests including many nurses from the city and county. Dr. Hartman spoke on "Ectopic Pregnancy" and Dr. Wiseley on "New Phases of Internal Medicine". It was announced that the next meeting would be held April 5 at the hotel.—News Clipping.

Seneca County Medical Society held its regular meeting February 18 at the Shawhan Hotel, Tiffin. Motion pictures showing new technic in the use and administration of spinal anesthesia were presented.—News Clipping.

Van Wert County Medical Society held its regular meeting March 1 at the Van Wert County Hospital with a good attendance. Dr. R. O. Ruch, Lima, gave an address on "Skin Diseases" which was illustrated and emphasized the principal points in diagnosis as well as treatment of many of the diseases.—News Clipping.

Fourth District

ACADEMY OF MEDICINE OF TOLEDO AND LUCAS COUNTY

(A. P. Hancuff, M.D., Secretary)

March 4—General Session. Program: "Causes and Prevention of Cardio-pulmonary Complications in Thoracic Surgery for Tuberculosis", Dr. Pol N. Coryllos, professor of clinical surgery, Cornell University Medical College.

March 11—Section of Pathology, Experimental Medicine and Bacteriology. Program: "The Scientific Autopsy in Toledo Hospitals—A Survey", Dr. J. B. Rucker, Jr.; "Some Legal Aspects of the Autopsy", Dr. Paul Hohly; "A Typical Autopsy Report", Dr. T. L. Ramsey.

March 18—Joint Meeting of the Medical Section and Toledo Public Health Association. Program: "The Childhood Type of Tuberculosis", Dr. Henry D. Chadwick, Herman Kiefer Memorial Hospital, Detroit.

March 21-25, inclusive—Tenth Post-Graduate Course conducted by Dr. A. J. Carlson, professor of physiology, University of Chicago. Subject: "Recent Advances in Physiology". Program: March 21, 4:30 p. m., "The Blood; Blood Coagulation; the Anemias"; 8:30 p. m., "Control of the Heart"; March 22, 4:30 p. m., "Control of Blood Pressure"; 8:30 p. m., "The Respiratory Mechanism; the Problem of Oxygen Therapy"; March 23, 4:30 p. m., "The Digestive Secretions"; 8:30 p. m., "The Motor Mechanisms of the Alimentary Tract; Constipation"; March 24, 4:30 p. m., "The Adequate Diet; Dietary Deficiencies"; 8:30 p. m., "The Endocrines"; March 25, 4:30 p. m., "The Endocrines; Present Status of Gland Therapy"; 8:30 p. m., "Renal Function".

Four County Medical Society met Thursday, February 18 at the High School Building, Bryan, following a chicken dinner at the Jefferson Hotel. The program for the meeting was arranged by the Williams County Medical Society and consisted of a "Symposium on Arthritis" by members of the Academy of Medicine of Lima and Allen County. Following "Introductory Remarks" by Dr. E. B. Pedlow the following papers were presented: "Economic Losses", Dr. G. E. Jones, with statistics from life insurance companies, health departments and industrial boards; "Classification and Symptomatology", Dr. R. O. Ruch; "Etiology—Focal Infections", Dr. F. G. Maurer; "Etiology-Gastrointestinal Factors", Dr. G. E. Miller; "Treatment—Medical, Diathermic, Electrical, Physiotherapy", Dr. Burt Hibbard; "Treatment—Surgical", Dr. E. B. Pedlow.—D. J. Slosser, M.D., Secretary.

Sandusky County Medical Society met with the medical and surgical staff of the Memorial Hospital, Fremont, March 1, at the hospital. The following program was presented: "Bilateral Quinsey—Death", Dr. J. C. Boyce; "Miliary Tuberculosis", Dr. E. M. Ickes, and "Obstruction of the Bowels Due to Carcinoma of the Sigmoid", Dr. F. L. Moore.—News Clipping.

Wood County Medical Society held its regular monthly meeting February 18 at the Woman's Building, Bowling Green, with eighteen in attendance. Following a short business meeting, the society went to the assembly room at the court house where Dr. C. C. Greiner, Pemberville, addressed the society and the public on "Reflexes and Treatment".—News Clipping.

Fifth District

ACADEMY OF MEDICINE OF CLEVELAND

(Clarence H. Heyman, M.D., Secretary)

March 4—Clinical and Pathological Section. Demonstrations at City Hospital.

March 9—Obstetrical and Gynecological Sec-

tion. Program: "Demonstration of Two New Instruments", Dr. William D. Fullerton; "Interrelationship of Anterior Pituitary and Ovary", Dr. B. S. Kline; "Ovarian Hormones", Dr. E. P. McCullagh.

March 11—Experimental Medicine Section. Institute of Pathology. Program: "The Dissociation of Microbacteria into Non-Acid Fast Forms", Dr. F. R. Miller; "Pellagra: Response to an Unorthodox Diet", Dr. T. D. Spies; "The Excretion of Sulphate", Dr. J. M. Hayman, Jr.; "Gastric Acidity in Various Stages of Graves' Disease", Dr. W. R. Berryhill; "The Antianemic Property of Human and Bovine Gastric Juice", Dr. H. A. Williams; "Further Evidence of Thebesian Arterial Connections", Drs. J. T. Wearn, T. G. Klumpp and L. J. Zschiesche.

March 18—General Session. Auditorium. Program: "The Neurological Aspects of Pernicious Anemia", Dr. M. A. Blankenhorn; "The Outlook of the Patient with Pernicious Anemia", Dr. Cyrus C. Sturgis, professor of internal medicine, University of Michigan Medical School, Ann Arbor.

Ashtabula County Medical Society held its annual dinner-dance February 9 for members of the society and dentists and druggists of the county and their ladies. Dinner was served to 40 at the Hotel Ashtabula. Dr. P. J. Collander, president of the society, presided as toastmaster. He introduced Ford B. Russell, cashier of the Farmers' National Bank and Trust Company, who addressed the guests on "Success". Following a program of vocal and instrumental music, dancing was enjoyed until a late hour. The affair was arranged by Dr. Collander, Dr. E. H. Merrill, secretary of the society, Dr. R. B. Wynkoop, Dr. W. S. Gessler and Dr. Bernice A. Fleek.—News Clipping.

Huron County Medical Society at its regular meeting February 16 at the American Legion rooms, Norwalk, was addressed by Dr. C. H. Heyman, Cleveland. A supper was served following the meeting.—News Clipping.

Lorain County Medical Society met in regular session March 8 at the Antlers Hotel. Following dinner, a program on pneumonia was presented, Dr. G. S. Shibley, associate professor of medicine, Western Reserve University, delivering the principal address, with special reference to serum treatment. Dr. Benjamin Carlson, Lorain, who was to have spoken on the same subject was unable to be present because of illness. There was a good attendance and the discussion was enjoyed by all. It was announced that the membership of the society had reached the 100 mark, a gain of three members over 1931 not deducting losses from death.—W. E. Hart, M.D., Secretary.

Medina County Medical Society met February 18 in the headquarters of the county board of health, following a joint dinner with the members of the Medina Kiwanis Club. The principal address of the evening was made by Dr. H. G. Southard, State Director of Health. Members of the board of health and employes of the department were present. It was announced that in the near future the society would be addressed by Dr. H. H. Dorr, chief medical examiner of the State Industrial Commission and that arrangements also were being made to have Dr. John Dickenson, Cleveland, speak to the society on cranio-cerebral injuries.—J. K. Durling, M.D., Secretary.

Trumbull County Medical Society sponsored a public program February 18 at the Y.W.C.A. at Warren in connection with the public health campaign being staged by the Y.W.C.A. A large audience heard Dr. H. G. Sloan, Cleveland, speak on "Cancer". He emphasized preventive activities and warned his audience against quacks and worthless remedies.—News Clipping.

Sixth District

Ashland County Medical Society held its regular meeting Friday evening, March 11, at the Samaritan Hospital, Ashland. The society was favored with a brilliant paper by Dr. J. M. Heyde, Loudonville, on "The Vegetative Nervous System and Its Physiology". Dr. Heyde discussed the anatomical origin of the sympathetic and parasympathetic nerve structures and their distribution and functions. He stressed the importance of understanding the functions of these nerves which control all the vital automatic functions of the body in order to correctly treat abnormal activities of the heart, lungs and digestive organs. Dr. George Riebel, Ashland, presented two interesting cases, one of sinus infection and the other of recurrent mastoiditis in a child. He discussed the importance of early diagnosis in mastoiditis and the best methods available. He also stressed the importance of radical measures in certain cases of frontal sinus disease.

The society held its annual banquet February 19 at the Ashland Country Club. Covers were laid for 30 members of the society, their wives and guests, on tables attractively decorated with carnations, red taper candles and flags in commemoration of Washington's Birthday. Dr. W. F. Emery, president of the society, presided as toastmaster and presented the guest speaker, Dr. Louis Karnosh, Cleveland, who spoke on "Insanities of Famous People". Dr. Karnosh described in a vivid and intensely interesting way the peculiar characteristics, emotional instabilities, intense hatreds, loves, and mental twists which were vital factors in the lives of Michelangelo, Rembrandt, Lord Byron, Edgar Allen Poe, Beethoven, Listz, Voltaire, etc., and which controlled to a great extent the expression of their art. Several members of the society also were called upon for a few remarks. Those who responded were:

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Dr. Thomas, Jeromesville; Dr. Kellogg, Ashland, Dr. Paisley, Loudonville and Dr. Smith, New London.—Paul E. Kellogg, M.D., Secretary.

Mahoning County Medical Society was addressed by Dr. John Tucker, Cleveland, at its regular meeting March 15 at the Youngstown Club. Dr. Tucker, who has been associated with the Cleveland Clinic since its inception, spoke on "Newer Viewpoints In the Treatment of Peptic Ulcer". Following the program a social hour was enjoyed.—D. J. Rosenfeld, M.D., Correspondent.

Portage County Medical Society held its regular meeting March 3 at the office of Dr. J. H. Krape, Kent, with a good attendance. The program was opened by Dr. W. B. Andrews, Kent, who presented a case report on "Angioneurotic Edema of the Throat". The principal address of the evening was made by Dr. Russell L. Haden, Cleveland, who spoke on "Some of the Newer Conceptions of Anemia". The talk was illustrated with graphic charts and was an unusually instructive and valuable presentation.—E. J. Widdecombe, M.D., Secretary.

Stark County Medical Society was addressed by Dr. M. A. Blankenhorn, Cleveland, at its regular meeting March 8 at the Canton Elks' Club. Dr. Blankenhorn spoke on "Hospital Treatment of Lobar Pneumonia". The paper was discussed by Dr. G. F. Zinninger and Dr. C. A. Lamont.—F. S. Van Dyke, M.D., Secretary.

Summit County Medical Society met in regular session March 1 at the Akron City Club. The guest speaker of the evening was Dr. M. R. Reid, professor of surgery, University of Cincinnati, College of Medicine. Dr. Reid read a paper on "Surgery of the Sympathetic Nervous System".—A. S. McCormick, M.D., Secretary.

Wayne County Medical Society held its regular meeting February 9 with Dr. Walter G. Stern, Cleveland, as the guest speaker. Dr. Stern gave the society an interesting address on "The Doctor In Court" from a doctor's standpoint. The talk was replete with wit, humor and facts, and sound advice of value to every practitioner. Dr. E. H. McKinney, Doylestown, was installed as president along with other officers and committeemen. Two new members were elected, giving the society the largest membership it has ever had. Following the meeting, the members chatted about the visit on February 4 to the home of Dr. Joe H. Todd on his 95th birthday. Members of the society found Dr. Todd in his usual good health and looking as if he may have quite a few more birthday celebrations. In his keen and scholarly manner, Dr. Todd recounted for his guests the manner of diagnosing and treating diseases when he began practice in 1865. He is still quite active in his professional duties. The next oldest practitioners in the county are Dr. A. E. Stepfield, Doylestown, and Dr. H. N. Mateer, Wooster, both of whom have been in active practice since 1883.—R. C. Paul, M.D., Secretary.

Seventh District

Belmont County Medical Society held its regular meeting March 3 at the Kilkenny Inn, near St. Clairsville, with Dr. C. A. Bicking, Pittsburgh, as the guest speaker. Dr. Bicking gave an illustrated lecture on "Traumatic Surgery of the Extremities". Those who took part in the discussion which followed were Dr. C. B. Messerly, Martins Ferry, Dr. F. S. Wright, Bellaire, and Dr. P. L. Ring, Bellaire.—F. R. Dew, M.D., Correspondent.

Columbiana County Medical Society met March 8 at the Roller Tea Room, Columbiana. Dr. L. W. King, Salem, made the principal address on "Ear Complications of Influenza". Following the program, dinner was served and a social hour enjoyed.—T. T. Church, M.D., Secretary.

Coshocton County Medical Society met February 26 at the City Hospital, Coshocton. The program was presented by Dr. T. W. Lear and Dr. L. D. Lebold.—News Clipping.

Tuscarawas County Medical Society held its regular meeting March 10 at the Twin City Hospital, Dennison. The guest speaker was Dr. W. Eugene Masters, Columbus, who spoke on "The Use of the Modern Classification of Heart Disease in Practice".—Bulletin.

Eighth District

Fairfield County Medical Society held a luncheon meeting February 9 at the Florentine, Lancaster. Twenty members of the society attended and heard a talk on "Rickets" by Dr. E. H. Baxter, Columbus.—News Clipping.

Guernsey County Medical Society met with a good attendance on February 18 for a luncheon and general discussion of medical questions.—News Clipping.

Licking County Medical Society at its regular meeting on February 26 at the Warden Hotel, Newark, was addressed by Dr. L. A. Mitchell,

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Newark, on "The Importance and Significance of Leukocyte Counts in Diagnosis".—News Clipping.

Muskingum County Medical Society met in regular session March 2 at the American Legion headquarters. The guest speakers were Dr. George T. Harding, Jr., and Dr. George T. Harding, III, both of Columbus. The former spoke on "Intoxication Psychoses and the Bromides" and the latter on "Psychoneuroses, With Illustrative Cases".—Beatrice T. Hagen, M.D., Secretary.

Perry County Medical Society held a luncheon meeting February 15 at the Park Hotel, New Lexington. Dr. R. W. Miller, Hemlock, was the principal speaker. He reviewed a case of surgery for tuberculosis.—F. J. Crosbie, M.D., Secretary.

Ninth District

Jackson County Medical Society at its regular meeting March 1 at the City Hall, Jackson, was addressed by Dr. Louis Mark, Columbus, on "Bronchiectasis and Allied Pulmonary Conditions With Upper Respiratory Infection". There was a good attendance.—J. J. McClung, M.D., Secretary.

Tenth District

COLUMBUS ACADEMY OF MEDICINE

(John H. Mitchell, M.D., Secretary)

March 1—General Session. Columbus Public Library. Program: "Pernicious Anemia", Dr. Cyrus Sturgis, Ann Arbor, Michigan.

March 14—General Session. Columbus Public Library. Program: "Some Manifestations of Allergy", Dr. Jonathan Forman, Columbus.

March 21—General Session. St. Francis Hospital. Clinical program by the hospital staff.

March 28—General Practitioners' Section. Columbus Public Library. Program: "The Opportunities of the General Practitioner; An Internal Abdominal Disease", Dr. F. F. Lawrence; "*X*-ray for the General Practitioner", Dr. Luther Adams.

Crawford County Medical Society met March 7 at the Elks' Home. Dr. P. I. Tussing, Lima, was the guest speaker. The subject of his paper was "Coronary Thrombosis In Its Relation to Angina Pectoris". Following the address, a buffet luncheon was served.—Bulletin.

Pickaway County Medical Society held a joint meeting February 4 with the Board of Trustees of the Berger Hospital, Circleville. Questions concerning the operation of the hospital were discussed.—News Clipping.

William J. Kennedy, former assistant director of the State Department of Public Welfare, has been appointed service director of Cleveland by Mayor Ray T. Miller. A successor to Mr. Kennedy has not as yet been appointed.

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Thirty-Third Annual Meeting of the American Proctologic Society will be held at Memphis, Tennessee, Friday and Saturday, May 6 and 7. The headquarters will be at the Peabody Hotel where most of the sessions will be held.

Dr. John Dudley Dunham, Columbus, an officer of the American College of Physicians, is planning to fly to San Francisco where he will attend and take part in the Annual Meeting of the College, April 4 to 8, inclusive. Dr. Dunham will conduct the gastroenterology clinic on April 7, one of the features of the scientific program.

The following officers have been elected by the Ohio Mental Hygiene Association: President, Dr. H. C. Schumacher, Cleveland; first vice president, Mrs. Simon Ross, Cincinnati; second vice president, Dudley Blossom, Cleveland; secretary, M. J. Gibbons, Jr., Dayton; treasurer, R. E. Miles, Columbus, and executive secretary, Charles L. Sherwood, Columbus. Other members of the executive committee are: R. G. Patterson and Charles S. Berry, Columbus.

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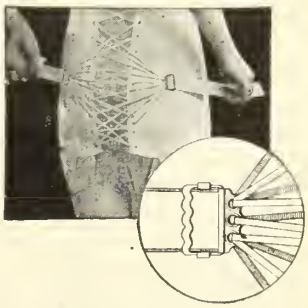
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Deaths in Ohio

William E. Allaman, M.D., Dayton; Ohio Medical University, Columbus, 1902; aged 60; member of the Ohio State Medical Association and of the American Medical Association; died February 27 of pneumonia. Dr. Allaman was born in Butler County and educated in the public schools of that county. Following his graduation from Ohio State University, he became a field worker for the Anti-Saloon League, engaging in that work for three years before entering medical school. Dr. Allaman located in Dayton in 1903. He was a member of the Masonic and Knights of Pythias lodges, the Junior Order and the First United Brethren Church. His widow, three sons, three brothers and four sisters survive.

Frank M. Burns, M.D., Cincinnati; Medical College of Ohio, Cincinnati, 1900; aged 57; member of the Ohio State Medical Association and the American Medical Association; died February 29 following a six months illness. Dr. Burns was a member of the Knights of Columbus and the Catholic Order of Foresters. During the World War, he served as a captain in the Medical Corps, being assigned to troop transports. A son, two daughters, a sister and a brother survive.

Kile M. Ellsworth, M.D., Dayton; Eclectic Medical College, Cincinnati, 1899; aged 71; member of the Ohio State Medical Association and American Medical Association; died March 6. Dr. Ellsworth located in Dayton in 1900. He was a native of Catawba, Ohio. He was a member of the Masonic Lodge and the Woodmen of the World. His widow survives.

Clarence E. Exline, M.D., Canton; Ohio Medical University, Columbus, 1897; aged 61; former member of the Ohio State Medical Association and the American Medical Association; died February 17 of pernicious anemia. Dr. Exline was born in Pike County and attended Mt. Union College previous to entering medical school. During the World War he served as a lieutenant in the Medical Corps. Dr. Exline was a member of the following organizations: First United Brethren Church, Modern Woodmen, Odd Fellows, Knights of Pythias, American Legion and Loyal Order of Moose. He leaves a widow, one daughter, two brothers and one sister.

Angela B. Farley, M.D., Cincinanti; Miami Medical College, Cincinnati, 1906; aged 53; former member of the Ohio State Medical Association and the American Medical Association; died February 10. Dr. Farley had been in active practice for more than 25 years. She was a member of the Catholic Women's Association, Catholic Ladies of Columbia, Daughters of Isabella, Ladies' Auxiliary to the Ancient Order of Hibernians; Ladies' Auxiliary to the Knights of St. John, and the Catholic Big Sisters. Surviving are four brothers and one sister.

Ferdinand H. Gentseh, M.D., New Philadelphia; University of Wooster Medical Department, Cleveland, 1878; aged 84; died February 15 following a six months illness. Dr. Gentsch was a life-long resident of New Philadelphia. He attended the U. S. Naval Academy, Annapolis, and served four years in the Navy before entering medical school. Dr. Gentsch was a member of the Masonic and Odd Fellows lodges. His widow survives.

George A. Haveman, M.D., Columbus; Miami Medical College, Cincinnati, 1905; aged 50; member of the Ohio State Medical Association and the American Medical Association; died February 20. Dr. Haveman moved to Columbus from New Bremen about 10 years ago. He served overseas with the Medical Corps during the World War. He is survived by his widow, one daughter, his mother, two brothers and two sisters.

Charles F. Hera, New Richmond; licensed in 1896; aged 76; member of the Ohio State Medical Association and the American Medical Association; died February 2. Dr. Hera was a native of



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Baltimore, Maryland. For 25 years he was on the staff of the fire and police medical service at Cincinnati and on the faculty of the Eclectic Medical College in that city. For the past 30 years he had been a resident of New Richmond. Dr. Hera is survived by his widow and one son.

Hal W. Hogue, M.D., Montpelier; Northwestern University Medical School, 1913; aged 42; former member of the Ohio State Medical Association; member of the West Virginia State Medical Association, and Fellow of the American Medical Association; died February 19 of pneumonia. Dr. Hogue, formerly of Akron and White Sulphur Springs, West Virginia, had been associated with his father, Dr. Warren L. Hogue, Sr., Montpelier, for the past few months. For a time he was physician at the B. F. Goodrich Rubber Company, Akron. Besides his parents, he leaves one son, two brothers, one of whom is Dr. Warren L. Hogue, Jr., Akron, and one sister.

Samuel J. Irwin, M.D., Tarlton; Medical College of Ohio, 1887; aged 68; died February 23 following a two weeks illness. Dr. Irwin was a native of Pickaway County and following his graduation from medical school located in Tarlton in 1888. He was a prominent Mason and a member of the county board of health and had always been active in military matters, being at one time a member of Company M, Regiment 14, Ohio National Guard. He belonged to the Methodist Episcopal Church. Surviving are his widow, four daughters and three brothers.

William H. Krieger, M.D., Cincinnati; Eclectic Medical College, Cincinnati, 1886; aged 85; died March 2. Dr. Krieger retired two years ago after 42 years of active practice. He was a native of Germany. Surviving is his widow.

Jacob G. Lawrence, M.D., Canton; School of Medicine, Western Reserve University, 1897; aged 66; member of the Ohio State Medical Association and Fellow of the American Medical Association; died February 17 following a heart attack. Dr. Lawrence has been a practicing physician in Canton for the past 23 years. He was a native of Stark County and practiced for a time in Ashtabula County and at Bowdil, Stark County, before moving to Canton. He had been county physician for many years. Dr. Lawrence leaves his widow, one son, Dr. Leslie Lawrence, Canton, four brothers and one sister.

T. Dayton Meguire, M.D., Cincinnati; University of Louisville, School of Medicine, 1892; aged 66; died February 22 following a week's illness. He had practiced in North Cincinnati for 30 years and was former president of the Northside Business Men's Club. He leaves three daughters.

George W. Miller, M.D., Mansfield; Kentucky School of Medicine, Louisville, 1894; aged 66; died March 2, following a heart attack. Dr. Miller was born in Bellefontaine and following his graduation from medical school located in Mansfield. He was a member of various Masonic orders and the First Methodist Church. Dr. Miller served two terms as county coroner and was medical examiner for several fraternal orders. He is survived by his widow and three daughters.

William Finley Moss, M.D., Maineville, Warren County; Starling Medical College, Columbus, 1882; aged 76; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died February 24 of a heart attack. Dr. Moss was one of the old-time country doctors of southwestern Ohio. He celebrated the 50th anniversary of his graduation from medical school on the day preceding his death. For many years, Dr. Moss' old white horse and ancient buggy was a familiar sight on the country roads of Warren County and it was not until recently that he began making calls in an automobile. He is survived by his widow, three daughters and two sons, one of whom is Dr. L. Conner Moss, until recently chief receiving physician at the Cincinnati General Hospital who is now engaged in research

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J.A.M.A., Dec. 19, 1931, p. 1914

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John I. Newcomb, M.D., West Unity; University of Michigan Medical School, 1888; aged 75; former member of the Ohio State Medical Association and the American Medical Association; died February 8 of heart disease. Dr. Newcomb, a native of Richland County, practiced for a time at Evansport before moving to West Unity in 1892. He was a member of the Methodist Episcopal Church and the Masonic Lodge. Surviving are his widow and three sons.

John B. Plent, M.D., Cleveland; New York University Medical College, New York, 1891; aged 76; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died February 16 of heart disease. Dr. Plent was a native of Austria, coming to this country with his parents in 1872. He came to Cleveland about 1892 and was for a time district physician for the city. Dr. Plent was a founder and for many years secretary of the Vcela Building and Loan Association and a director of the Oul Building and Loan Association. He retired from active practice several years ago. Surviving are his widow, one daughter and two sons, one of whom is Dr. John B. Plent, Jr., Cleveland.

John R. Pipes, M.D., Avon Lake; School of Medicine, Western Reserve University, 1888; aged 67; member of the Ohio State Medical Association and the American Medical Association; died February 21 following a brief illness. Dr. Pipes was former mayor of Avon Lake. He entered the practice of medicine in Cleveland in 1888 and moved to Avon Lake in 1891. Dr. Pipes was active in civic and charitable projects, and was a past president of the Lorain County Medical Society. His widow survives.

Louis Stricker, M.D., Cincinnati; Medical College of Ohio, Cincinnati, 1891; aged 69; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died March 14 following a long illness. Dr. Stricker, a native of Cincinnati, after completing his medical studies at the University of Heidelberg, Germany, returned to Cincinnati to practice. For many years he was chief of the staff of the ophthalmological service at Jewish Hospital and was doctor emeritus of the hospital at the time of his death. Fifteen years ago he established the conservation of vision classes in the Cincinnati Public Schools. Retiring a number of years ago, Dr. Stricker devoted his time to the promotion of relief work among the blind. He was the founder of the Cincinnati Association for the Welfare of the Blind and at the time of his death was county director of relief for the blind under the Hamilton County Commissioners. Dr. Stricker leaves one son and one daughter.

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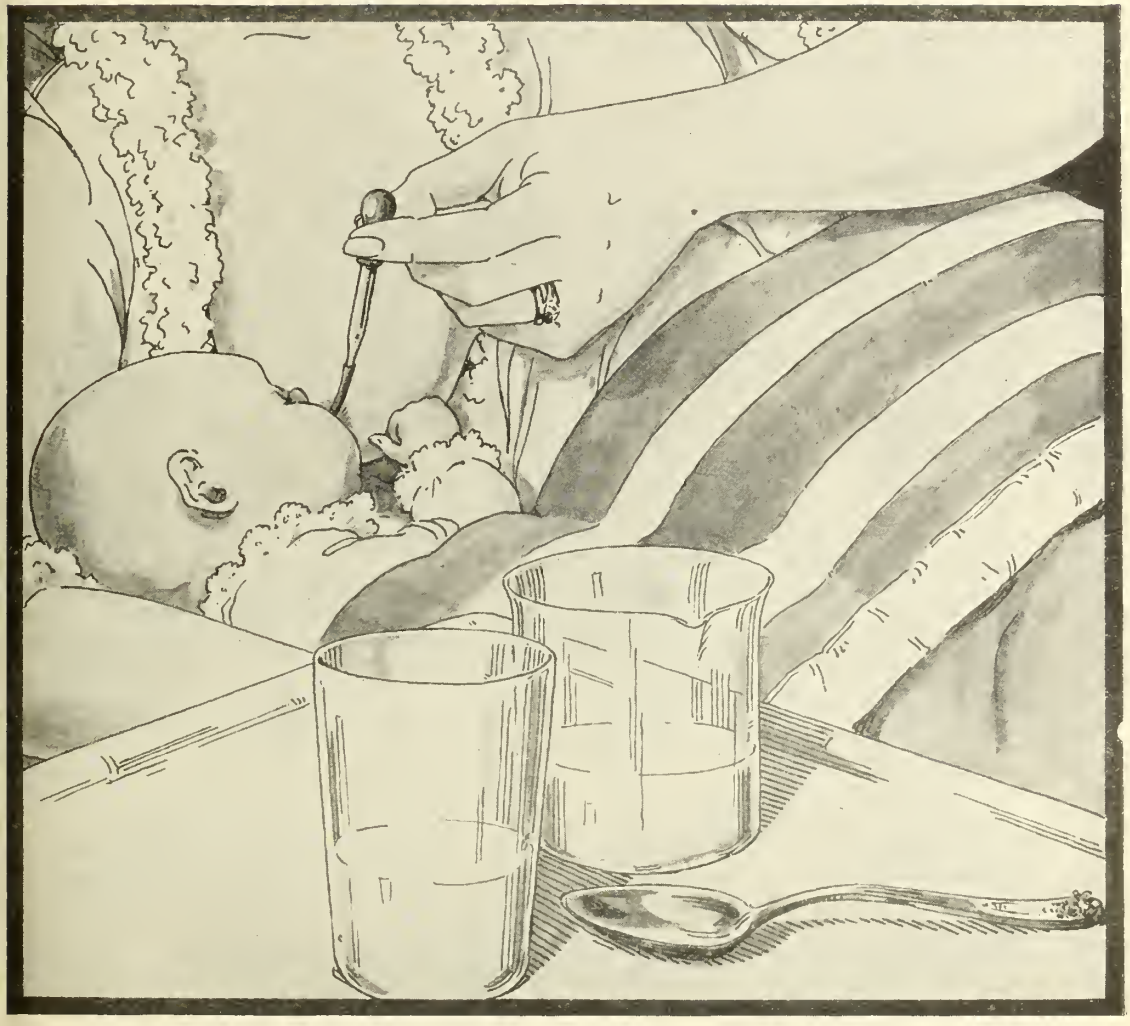
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Eighty-Sixth Annual Meeting, Dayton, May 3-4, 1932.

Annual Meeting, Dayton, May 3 and 4, 1932

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The OHIO STATE MEDICAL JOURNAL

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AS A MEDIUM OF SERVICE TO ITS MEMBERS

MAY 1, 1932

VOLUME XXVIII
Number - - 5

APR

ANNUAL REPORT NUMBER

This issue contains the Annual Reports of the Committees and Officers of the Ohio State Medical Association, which should be read and filed, for reference, by every member.

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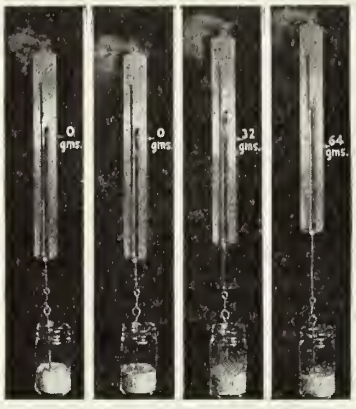
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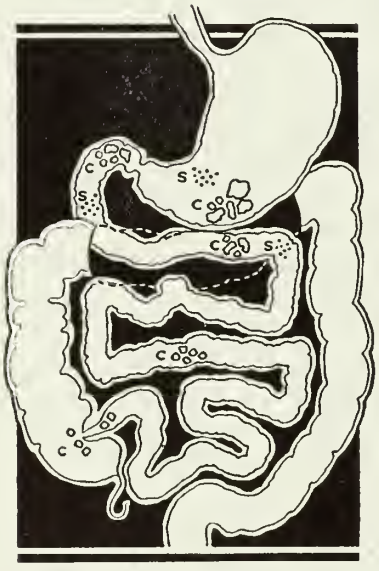
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[1] Marriott: Infant Nutrition, pg. 49.

[2] Talbot: Morse and Talbot, Diseases of Nutrition and Infant feeding, pg. 48.

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Highland	J. C. Bohl, Hillsboro	W. B. Roads, Hillsboro	1st Wednesday, monthly.
Warren	J. E. Witham, Waynesville	James Arnold, Lebanon	1st Tues. Apr., May, June, Sept., Oct., and Nov.
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Darke	C. F. Frankman, Greenville	W. D. Bishop, Greenville	1st Friday, monthly.
Greene	R. H. Grube, Xenia	Hugh Schick, Xenia	1st Thursday, monthly.
Miami	E. T. Pearson, West Milton	G. A. Woodhouse, Pleasant Hill	1st Friday, monthly, except July and August.
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Preble	J. I. Nisbet, Eaton	C. E. Newbold, Eaton	3d Thursday, monthly.
Shelby	A. B. Gudenkauf, Sidney	B. A. Welch, Sidney	1st Friday, monthly.
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Logan	A. J. McCracken, Bellefontaine	W. H. Carey, Bellefontaine	1st Friday, monthly.
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Seneca	E. H. Porter, Tiffin	R. E. Hershberger, Tiffin	3rd Thursday, monthly.
Van Wert	S. A. Edwards, Van Wert	R. H. Good, Van Wert	1st Tuesday, monthly.
Wyandot	B. A. Moloney, Upper Sandusky	J. Craig Bowman, Up. Sandusky	1st Thursday, monthly.
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Henry	T. P. Delventhal, Napoleon	F. M. Harrison, Napoleon	2nd Wednesday, monthly.
Lucas	E. B. Gillette, Toledo	A. P. Hancuff, Toledo	Friday, each week.
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Putnam	P. D. Bixel, Pandora	A. L. Fipp, Glandorf	1st Tuesday, monthly.
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Wood	O. S. Canright, Haskins	F. V. Boyle, Bowling Green	3d Thursday, monthly.
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Erie	H. W. Lehrer, Sandusky	G. A. Stimson, Sandusky	Last Wednesday, monthly, except July, Aug., Sept.
Geauga	W. C. Cory, Chardon	Isa Teed-Cramton, Burton	Last Wednesday, Apr. to Dec.
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Lake	W. P. Ellis, Painesville	B. T. Church, Painesville	4th Tuesday, monthly.
Lorain	David Thomas, Lorain	W. E. Hart, Elyria	2d Tuesday, monthly.
Medina	Harry Street, Litchfield	J. K. Durling, Wadsworth	1st Thursday.
Trumbull	Frank La Camera, Warren	R. H. McCaughtry, Warren	3d Thursday, monthly, except June, July, August.

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Holmes	L. E. Anderson, Mt. Hope	C. T. Bahler, Walnut Creek	1st Tuesday, quarterly, Jan., April, July, October.
Mahoning	A. E. Brant, Youngstown	W. M. Skipp, Youngstown	3d Tuesday, monthly.
Portage	Paul H. Zinkhan, Ravenna	E. J. Widdecombe, Kent	1st Thursday, monthly.
Richland	W. H. Buker, Bellville	P. A. Stoodt, Mansfield	3d Thursday, monthly.
Stark	J. B. Dougherty, Canton	F. S. VanDyke, Canton	2d Tuesday, monthly.
Summit	E. R. Stumpf, Barberton	A. S. McCormick, Akron	1st Tuesday, monthly.
Wayne	E. H. McKinney, Doylestown	R. C. Paul, Wooster	2d Tuesday, monthly.
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Carroll	(With Stark Co. Society)		
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Harrison	A. C. Grove, Jewett	W. C. Wallace, Hopedale	3d Wednesday, monthly.
Jefferson	Victor Biddle, Steubenville	John Y. Bevan, Steubenville	Last Thursday, monthly.
Monroe	G. W. Steward, Woodsfield	A. R. Burkhart, Woodsfield	2d Wednesday, monthly.
Tuscarawas	C. J. Miller, New Phila.	G. L. Sackett, New Phila.	2d Thursday, monthly.
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Licking	H. A. Campbell, Newark	G. A. Gressle, Newark	Last Friday, monthly.
Morgan	D. G. Ralston, McConnelsville	C. E. Northrup, McConnelsville	3d Wednesday, monthly.
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Noble			
Perry	Joseph Clouse, Somerset	F. J. Crosbie, New Lexington	3d Monday, monthly.
Washington	S. E. Edwards, Marietta	E. W. Hill, Jr., Marietta	2d Wednesday, monthly
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Gallia	O. A. Vornholt, Gallipolis	Milo Wilson, Gallipolis	1st Wed., Feb., May, Sept. and Dec.
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Jackson	J. S. Hunter, Jackson	J. J. McClung, Jackson	1st Tuesday, monthly.
Lawrence	Cosper Burton, Ironton	V. V. Smith, Ironton	1st Thursday, monthly.
Meigs	P. A. Jividen, Rutland	Byron Bing, Pomeroy	1st Thursday, April, July and Oct
Pike	Paul Jones, Stockdale	L. E. Wills, Waverly	1st Monday, monthly.
Scioto	C. M. Fitch, Portsmouth	Wm. E. Scaggs, Portsmouth	2d Monday, monthly.
Vinton	O. S. Cox, McArthur	H. S. James, McArthur	3d Wednesday, monthly
Tenth District			
Crawford	K. H. Barth, New Washington	A. E. Loyer, New Washington	1st Monday, monthly.
Delaware	A. R. Callander, Delaware	E. V. Arnold, Delaware	1st Tuesday, monthly.
Franklin	James H. Warren, Columbus	John H. Mitchell, Columbus	1st four Mondays.
Knox	S. O. Gantt, Centerburg	R. L. Eastman, Mt. Vernon	Last Thursday, monthly.
Madison	R. S. Postle, London	G. C. Scheetz, West Jefferson	4th Wednesday, monthly.
Morrow	W. D. Moccabee, Cardington	T. Caris, Mt. Gilead	1st Wednesday, monthly.
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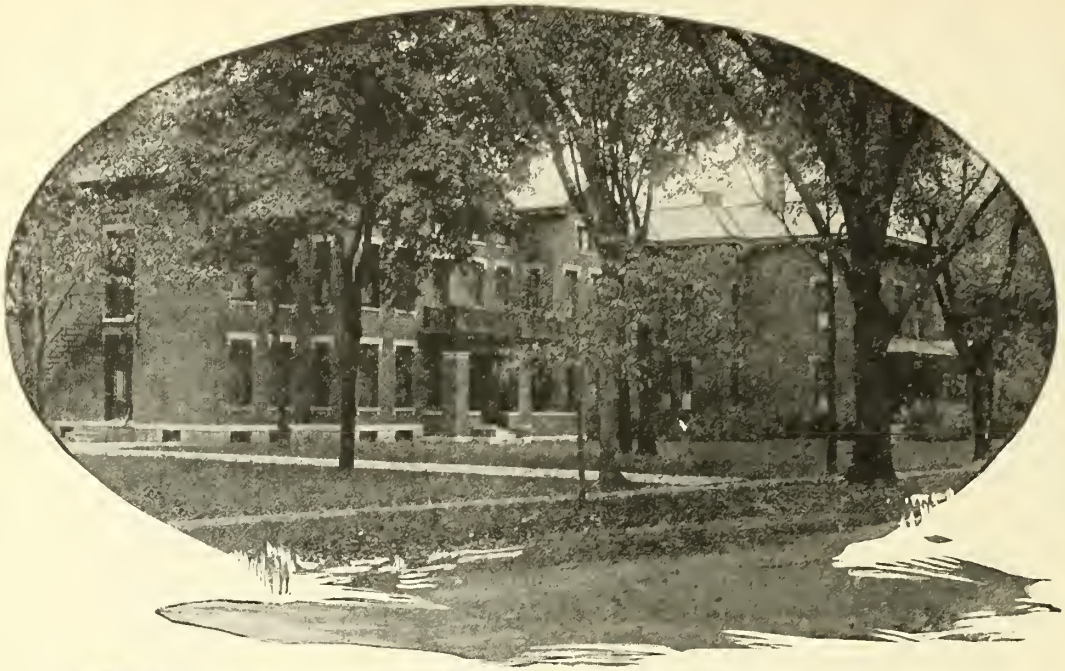
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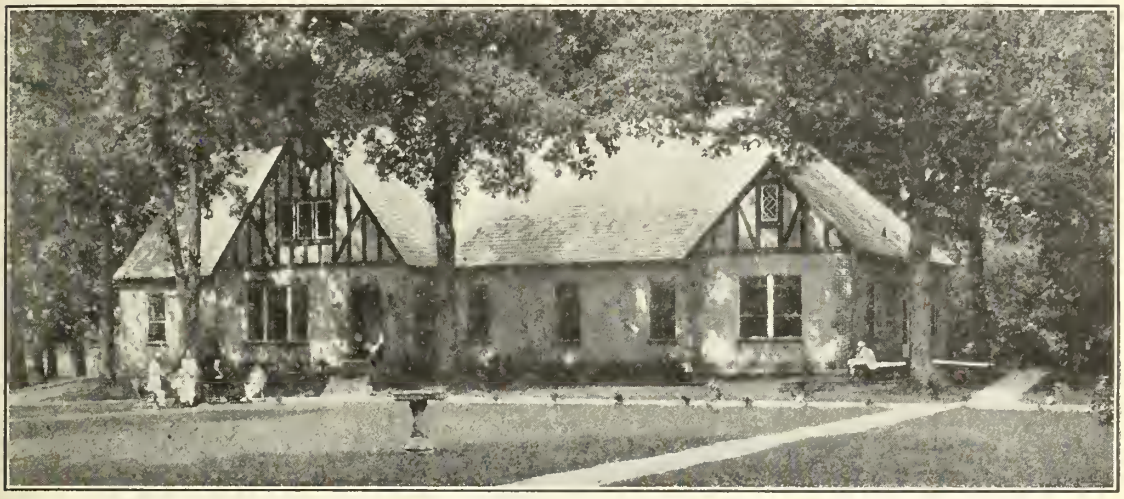
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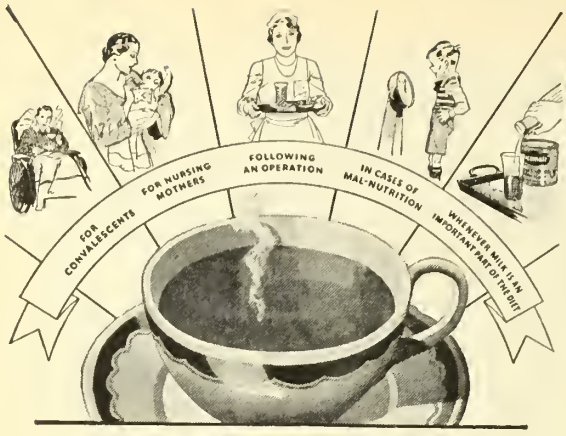
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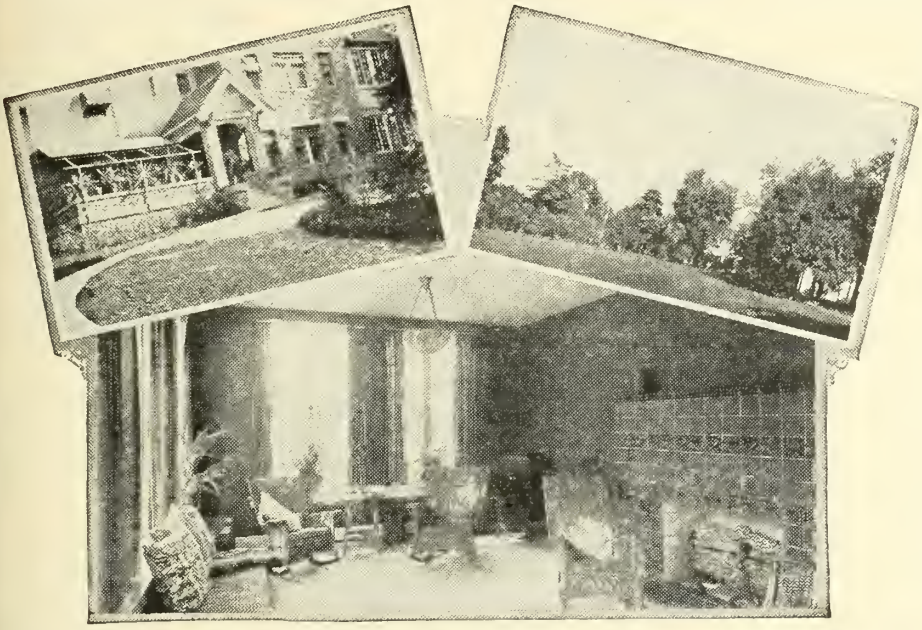
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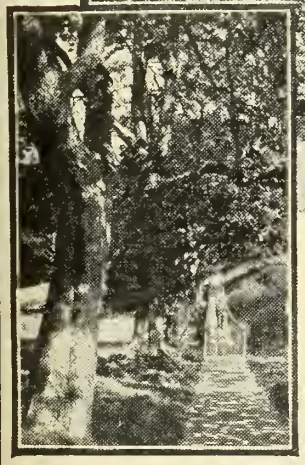
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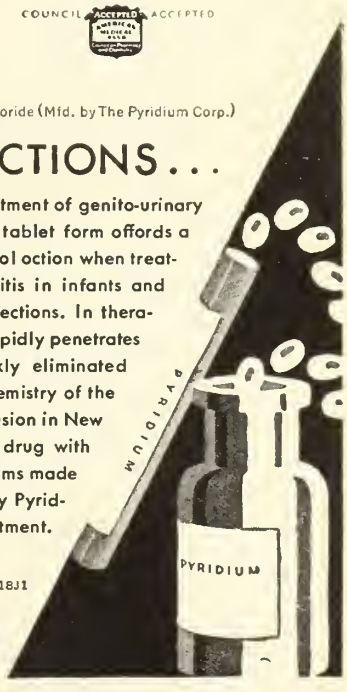
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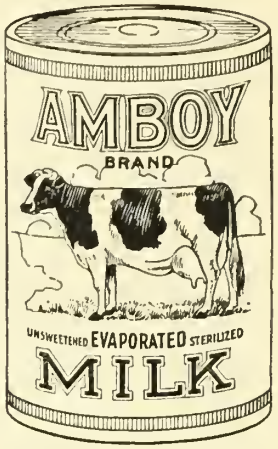
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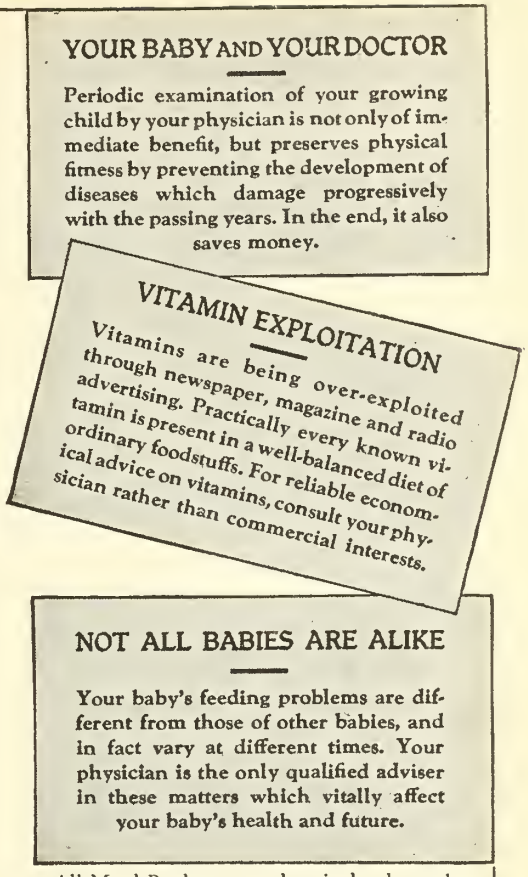
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PUBLIC HEALTH - SOCIAL WELFARE MEDICAL ECONOMICS and ORGANIZATION PROBLEMS

With Editorial Comment by D.K.M.

The Journal presents in this issue the annual reports of the officers, the councilors, and the standing and special committees of the State Association.

Annual Review of Organization Accomplishments

Realizing that there has never been a time when it has been more imperative for the medical profession to have as complete knowledge as possible and a full understanding of the vital questions now affecting scientific medicine, medical practice and public health, the officers, the council and the committeemen of the State Association have made a special effort to include in this year's reports analyses of as many different problems and issues as time and space will permit.

Many of the problems which have arisen from the current world-wide spirit of unrest and from sporadic demands for social and economic changes have been defined in a fearless and clear-cut manner. Authentic data have been assembled and presented. Possibilities and ultimate results of a lengthy list of proposals dealing with medical and public health matters have been considered and each judged in the light of well-established policies of medical organization which have always reacted to the benefit of the public generally and safeguarded the professional and personal interests of the individual physician.

There are several important reasons why these official records, reflecting in some degree the numerous and diversified activities of those selected by the membership to serve as key-men in medical organization and to represent the organized medical profession of Ohio in matters of state-wide and general interest, deserve the careful and studious consideration of all members of the State Association.

In the first place, the large number of vital problems discussed illustrate and emphasize in a forceful way the necessity for the existence of a strong and unified association such as the Ohio State Medical Association. Obviously, something more than individual effort and initiative will be required to solve many of these questions and to safeguard the interests of the profession generally. There must be a coordination of effort. There must be concerted and unified activity. There must exist mutual understanding and cooperation. In other words, there must be organized effort, offensively and defensively, such as that maintained and sponsored by the State Association with its various component county medical societies and academies of medicine.

Secondly, these reports, prepared after many conferences and careful consideration by the officers and committees, present a summary of some of the complex questions, together with policies applicable to each. Rapid social, economic and governmental changes and developments make it almost impossible for the individual physician to keep himself fully informed on these questions. Organization machinery has been established to collect information on these subjects, interpret them in the light of modern medical thought, and present this data and opinions through the medium of the annual reports for the information of the profession generally.

These reports, in the third place, reveal in a brief way the sincere and active endeavors being put forth by medical organization to bring about advances in scientific medicine, improve public health, and safeguard and preserve the interests of the medical profession. Suggestions for group activity are presented and activities which organized medicine has undertaken briefly reviewed.

Lastly, the reports reflect the meritorious manner in which the officers, members of the Council, and the various committeemen have discharged the important responsibilities delegated to them; how considerate they have been of the will and best interests of the majority of the membership, and how devoted they have been to the tasks assigned to them, many of which required the expenditure of much time and effort in meetings, conferences, correspondence and personal contacts with individuals and groups, within and outside of the medical profession. Much credit and sincere appreciation are due those occupying positions of responsibility in medical organization for their unselfish and untiring efforts during the past year and for the efficient way they have guided the affairs of the State Association.

Similiarly, credit and appreciation should be given to the great majority of the members of the State Association who have cooperated at all times with the officers, councilors and committeemen and furnished them with the active, as well as moral, support necessary to accomplish the aims and purposes of medical organization.

Annual Meeting Program Reminders

Final arrangements for the Eighty-Sixth Annual Meeting of the Ohio State Medical Association, to be held Tuesday and Wednesday, May 3 and 4, at Dayton, have been completed.

For many reasons this year's annual gathering will be one of the most interesting, as well as most important meetings ever held by the State Association, and, therefore, should be attended by as many of the members as possible.

Those who have studied the official program for the Dayton meeting, published in full in the April issue of *The Journal*, undoubtedly have been favorably impressed with the unusually large number of thought-provoking and scientifically-important subjects scheduled for discussion.

For the sake of emphasis, the attention of the membership is called to several changes which have been made in the customary set-up and schedule for some of the annual meeting events.

In order to provide a more opportune time for holding the Organization Luncheon and to relieve the usual congestion on the program of the final day of the meeting, this event will be held Tuesday noon, May 3, instead of Wednesday noon, as heretofore. The luncheon will follow the first session of the House of Delegates, scheduled for Tuesday morning, and will be concluded in plenty of time to permit the officers and committeemen to attend the first sessions of the Scientific Sections, scheduled to open at 2 o'clock, Tuesday afternoon.

The General Scientific Session will be held as usual on Wednesday afternoon but *will start at 1 p. m. instead of 3:30 p. m. as was customary.* The Program Committee in making this change did so to provide additional and a more convenient time for one of the scientific features of the meeting, namely: the coordinated symposia to be presented by the three Class A medical schools of Ohio—Western Reserve, University of Cincinnati and Ohio State University.

In order to avoid conflict so far as possible with this session which every member in attendance undoubtedly will desire to attend, the final session of the House of Delegates has been scheduled to start at 3:30 p. m. on Wednesday, instead of 1:30 p. m. as customary.

The special attention of those planning to attend the Dayton meeting is directed to the announcement published in the April issue of *The Journal*, Page 291, relative to the arrangements which have been made with the railroads for reduced fares to Dayton for members of the State Association. Due to a reduction this year in the minimum number which must take advantage of the "certificate" plan to make it operable, it is quite probable that the minimum will be easily obtained and that members will be able to save on traveling expenses to Dayton.

Also, members expecting to attend the meeting who have not as yet made hotel reservations should do so immediately. The information on Dayton hotels and their rates published in both the March issue and April issue of *The Journal* will be of assistance in selecting convenient hotel accommodations.

Considerable news concerning some of the special features of the annual meeting has been published from time to time in *The Journal*. Special attention is called to articles on the annual banquet, the scientific exhibit and the medical and surgical clinics published in the April issue of *The Journal*.

To facilitate registration at the Dayton meeting, members should be sure to have with them their 1932 State Association membership card. Only those who have paid their dues for 1932 may register and attend the various sessions, in conformity with the Constitution and By-Laws of the State Association.

A most successful gathering of the medical profession of the state at Dayton is indicated. Every member who can possibly do so should attend, not only because of the good which he will derive from the program and from association with professional colleagues, but because of the benefit accruing to medical organization and the profession generally from thoughtful consideration by a large portion of the membership of the numerous social and economic, as well as scientific, questions at present confronting the profession.

Medical Organization Versus Chaotic Medical Practice

Strong and active medical organization in every county in the nation will be the greatest single factor in the prevention of state medicine, in the opinion of Dr. A. J. McLaughlin, medical director of the United States Public Health Service, who in a recent public statement discussed among other things public health administration, proposed changes in the present system of medical practice in this country and the costs of sickness.

Commenting on the question of state medicine, Dr. McLaughlin said:

"An exaggerated sense of ethics makes many physicians shrink from anything like business organization; yet organization on a business basis, provision of clinic facilities, regulation of fees on a sliding scale basis, according to income, are essental if State Medicine is to be prevented.

* * *

"The advocates of State Medicine have claimed that the defects noted above in our public health activity would be corrected by State Medicine, because medical and surgical, and presumably preventive advice and treatment, would be available to all citizens without cost. One must admit that,

theoretically, under such a system treatment would be available to all, but what kind of treatment?

"If a crowded office in which the panel doctor gives a prescription, rushes one patient out, like a barber, calls 'next,' can satisfy the needs of scientific medicine, then the system might suffice. But today the average American citizen knows that he is entitled to better treatment than this. He has been educated to the point where he knows something of the newer methods and equipment used in modern diagnostics and treatment.

"To me State Medicine appears as a miserable makeshift. It is un-American, ultrapaternalistic, and destrucive of self-respect in both doctor and patient. It is a failure in Germany, in England and in other European countries. It is, from an American viewpoint, a pauperizing influence, wrong in principle and doomed to failure in practice if we should ever be foolish enough to try it. * * *

"Proper organization of county medical societies will make State Medicine impossible, enable the physician to retain his self-respect, and preserve that priceless, intimate confidential relation that should exist between physician and patient."

Dr. McLaughlin's advice, suggestions, criticism and warning, coming as they do from an employe of the government who is in a position to know about the workings of governmental agencies and something about the experiences of other countries in their attempts to make the socialism of medical practice a success, are worthy of considerable thought.

His statement is especially pertinent at this time of unsettled economic and social conditions when there are many significant reasons why the medical profession must safeguard the interests of the public and protect its own interests through the maintenance of strong, united and active organizations.

Buying Votes With Voters Money

In the wake of what amounts to the most concerted raid in the history of the nation on the Federal Treasury for all manner of welfare and relief projects has followed a loud outcry against governmental paternalism and bureaucracy.

Despite the seriousness and importance of the situation, the medical profession is justified in amusement at the loud and emphatic protestations being raised on all sides, pointing to the dangers of federal doles, the violation of state's rights and individual freedom, the evils of paternalism, and the menace of further extension of bureaucratic control by the Federal government.

But why amusement on the part of the medical profession?

Because the medical profession, frequently accused of having lagged behind the parade in the matter of interpreting social, economic, and governmental trends and tendencies, has for years been preaching from the same text which is now being used by others who apparently are just beginning to realize that America has already started on the road to paternalism which eventually leads to dole-itis and socialism.

From the pen of one well-known spokesman of national business interests comes the following protest:

"To acknowledge that Government owes the people a living is at once to abandon the integrity of the state and of its citizens. To yield to political expediency and opportunism will surely invite demonstration not only of the public finances but also of the social conscience of the American people, as the disastrous experience of England should so convincingly admonish us."

Another observer raises this point:

"Once you open the doors of the Federal Treasury to payments directly to voters, there is not enough character in the politicians to shut the doors again. They can buy votes lavishly and charge the costs against unseen taxpayers."

These are but samples of sentiment which is now being expressed openly by leaders in fields of endeavor which have heretofore shown too little concern over the mounting costs of government, the growth of bureaucracy and the increasing evils of paternalism.

Medical organization which long since rebelled against the encroachments of government on individual effort in matters of medicine and public health and has consistently emphasized the evils of socialized ventures of government into the fields of health and medicine, welcomes as allies those who are beginning to see the light.

"The United States has not gone so far on the road to paternalism that it cannot retrace its steps", one authority has pointed out, but the combined efforts, of all the forces now keenly aware of the menaces of present day developments, will be necessary to bring about a curtailment of elaborate programs now being undertaken by the Federal government, to prevent establishment of new ones for the purpose of appeasing the socially-minded minority or for political expediency.

Dangerous Advice Concerning Rabies

Propaganda recently distributed in Ohio by the organizers of a new association for the protection of dogs is reported to have contained the following advice to the public:

"If you are bitten refuse the Pasteur treatment. Just wash and disinfect the wound. Refuse to be frightened. The highest medical opinions discredit the mad dog scare."

It is unfortunate that groups formed for pre-

sumably worthy purposes often make themselves ridiculous by endeavoring to disseminate advice concerning questions about which they are ignorant or misadvised.

Many humane societies and organizations of animal lovers throughout the country are doing a splendid service for both man and beast.

Friends of the animal kingdom certainly have a perfect right to protest the enactment of laws and ordinances which would cause unnecessary pain and suffering among dogs and other animals.

Dog owners and dog lovers may be justified in objecting to the enactment of compulsory preinfectional antirabic vaccination laws and ordinances, inasmuch as many well-informed scientists are doubtful concerning the complete efficacy of vaccination in preventing rabies in animals.

Any individual has a perfect right to, and should, protest brutality and cruel treatment in connection with the use of animals in scientific experimentation. Medical organization always has taken the lead in attempting to prevent mistreatment of animals in laboratories and has constantly protested unnecessary suffering in research.

However, sentimental and hysterical individuals, lacking training in the medical sciences and refusing to recognize the merits of vaccines, serums, etc., as valuable weapons in the treatment and prevention of human diseases, certainly have no right to take it upon themselves to advise and counsel the public on medical and health questions. Neither have they a right to hinder and impede man's progress in his fight against human diseases and disabilities by condemning and protesting the use of dogs and other animals in medical research.

The medical profession holds no brief against those individuals and groups who in their desire to protect man's animal friends exercise sound judgment and refuse to be swayed by unreasoning fanaticism in their activities. On the other hand, the medical profession, for the good of human beings generally and in the advancement of scientific medicine, cannot permit to pass unanswered the illogical, false, and dangerous statements frequently made by those who place a greater value on animal than on human life.

A Temporary Lull In Anti-Medical Criticism

That there are straws in the wind which seem to indicate a change in attitude on the part of the public towards the medical profession; that the recent wave of criticism with its numerous complaints is now being supplanted by a tendency to weigh more carefully the service being rendered by the profession, with the net result that a more wholesome appreciation of doctors is developing, is the opinion of some writers.

Undoubtedly what those writers mean is that a change has taken place in the sentiment expressed in recent articles published in lay periodicals on medical subjects, and that the medical profession is beginning to get more nearly a 50-50 break in the more recent published comments dealing with health and medical topics.

The thoughtful and informed citizen has been, and still is, in sympathy with scientific medical progress, and still has confidence in the qualified, competent and ethical medical practitioner, despite the purported increase in the clientele of the medical quacks, the cultists and all the rest of the pseudo-scientific practitioners.

What has caused misgivings and created alarm in the ranks of the medical profession has been the attempts on the part of believers in fanatical and socialistic theories to destroy public confidence in the profession through their contributions to the lay press.

Furthermore, it has been anything but comforting to the hard-working practicing physician to note some of the questionable sentiments expressed publicly by certain well-known colleagues, prompted by a desire for publicity, and to discover later that these comments have been used as damaging ammunition by the self-appointed medical reformers and critics, in their destructive campaign against scientific medicine.

If the new "straws in the wind" indicate that the lay press has arrived at the conclusion that the medical profession after all is worth preserving and that those who have been agitating radical and unsound changes, in the medical set-up in this country, have tired of their efforts, admitting they have failed to sway public opinion against the medical practitioner, then there is reason to feel encouraged about the future.

That the present let-up in public attacks on the profession is merely the calm before another storm has been suggested.

Regardless of what may be the reason for the present slump in the mud-slinging activities of its foes, the medical profession, through organized medicine, must carry on as before, persistently aiming for a continued development of better understanding and greater friendliness between the profession and the public; preparing to meet future issues as they arise; assisting its members to be of greater service and value to their patients, and militantly denouncing those who would make the doctor a mere hireling or who attempt to coerce the public into adopting false, alluring but destructive quackery.

The fanatic, the agitator, the theorist reformer, the radical, and all the rest of the breeds that make it a business to stir up public discontent seldom know when they are licked—if they are—so there is every reason to believe that the armistice of the present should be regarded as a challenge to greater initiative and energy on the part of the medical profession in the future.

The Importance of Supplementing The Clinical with Laboratory Findings in Pulmonary Tuberculosis

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PULMONARY tuberculosis is a disease usually of insidious onset, and diagnosis and prognosis, as well as selective therapy, are often very difficult to determine in the individual case. The fact that a primary infection (childhood type) with the tubercle bacillus may localize and develop with quite different signs and symptoms from those presenting where reinfection (adult type) has taken place has further tended to confuse our understanding of the mechanism of the disease, its pathology and its control. It is therefore necessary for the clinician of the present day to utilize every available means for the study and analysis of those patients presenting obscure symptoms suggestive of tuberculosis.

Out of a vast amount of experience and investigation, in the very recent as well as the more remote past, there may be selected certain dependable procedures for the accumulation of data which have proved of value in the analysis and treatment of the tuberculous patient. These may be enumerated in the chronological order of their development, as follows:

1. History, individual and family.
2. Physical examination; with special attention to inspection, auscultation (râles), temperature, pulse and respiration.
3. Sputum examination for:
   a. The presence of acid-fast rods (Koch),
   b. Their quantitative distribution (Gaffky),
   c. Their qualitative character (relative acid-fastness, nature and size of rods, granules) (Muck, Petroff, Kahn),
   d. Single colony plating and pathogenesis study ("R" and "S" colony forms) (Petroff).
4. von Pirquet or Mantoux skin test with Old Tuberculin (children). This is an index of infection not of disease, particularly in the adult.
5. Repeated *X*-ray examination of the chest in pulmonary tuberculosis. The value of this procedure depends directly upon two factors, one, the technical skill used in taking the pictures, and two, the number of observations made for comparison and contrast over a period of time.
6. Erythrocyte sedimentation rate. Non-specific for tuberculosis but usually found to be increased over the normal when active tuberculous disease exists.
7. The blood count.
   a. The red blood cells are usually very slightly affected until the far-advanced stage of tuberculosis is reached. The hemoglobin is a more important index, (See Case 5).
   b. The total and differential counts of the white blood cells are important:
      1. Monocyte-lymphocyte ratio (normal 0.33). An increasing M/L index denotes advancing lesions, a decreasing index indicates healing. (Sabin, Doan, Cunningham)
      2. Qualitative changes in the monocytes toward the epithelioid type are of diagnostic significance (Sabin, Doan)
      3. Qualitative changes in the lymphocytes toward the immature forms are of unfavorable prognostic significance (Wiseman).
      4. A "septic" neutrophilic increase is significant of caseation and cavitation (Medlar).
   c. Blood platelets are relatively unaffected.
8. The phosphatide precipitin test (Doan). The newer biochemical studies have related the lipoids of the tubercle bacillus to tubercle formation and it may be possible to measure the serologic ability of tuberculous individuals to limit the spread of the specific lesions.

The comparative importance and value of the above data have never been determined on the same group of tuberculous patients in terms of their actual clinical progress, though each procedure mentioned has made some contribution in the past to the understanding of individual cases.

CASES STUDIED

During recent months we have cooperated with Doctors Probst and Miller of the Franklin County Tuberculosis Sanatorium in the study of a small group of selected tuberculous patients. Weekly observations on this group have been made in terms of all of the above mentioned criteria, together with less intensive studies on a larger group of patients. Table I summarizes the findings in certain cases at the beginning of the observations in January, 1931, and again on May

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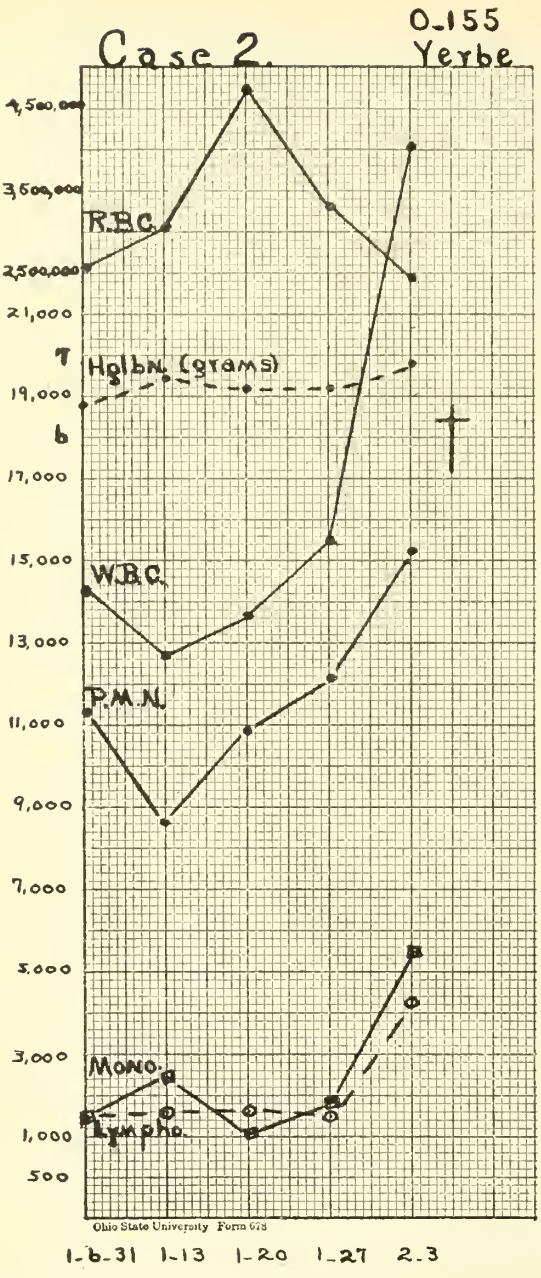


Chart 1. Fatal case of pulmonary tuberculosis. Note the terminal leucocytosis with the monocyte-lymphocyte ratio reversed and the low level of hemoglobin.

1, 1931, and are indicative of the progress of the disease in each patient during this period. The cases are arranged in the order of their severity, the first four having died during the period of study. Our observations are still in progress, so that the present resumé is in the nature of a preliminary report. The detailed weekly observations on the cells of the blood in a few representative cases only are presented at this time in the accompanying charts, 1, 2 and 3.

Of the twelve cases included in the present report, seven were men, five were women; eleven were white, one was colored; and eleven were between seventeen and twenty-six years of age. The probable duration of tuberculous disease ranged from eight months to seven years, and all but one of the cases had been classified as *far advanced*, on the basis of lesions as revealed by *X*-ray plates of the chest. Yet, the wide diversity of clinical and pathological manifestations exhibited within this one classification suggests the need for additional data as a guide to treatment and a more rational basis for prognosis. However, carefully taken repeated chest plates are most important in the following of all cases of pulmonary tuberculosis.

SPUTUM EXAMINATION

While it will be seen from Table I that those cases having the most marked clinical symptoms and the greatest pulmonary involvement have tended to show the largest number of acid-fast organisms in the sputum, there have been notable exceptions to the rule. It is our experience that the type and character of the acid-fast rods more accurately reflect the immediate seriousness of the condition than the number. When fine, slender, faintly acid-fast rods and granules were present, scattered singly rather than in clumps, a period of rapid dissemination of the disease usually existed. This type of organism predominated in all four of the cases in this series which ended fatally during the period of observation. On the other hand, large numbers of thick, clubbed, strongly acid-fast, branching rods in *clumps* when present were not necessarily incompatible with quiescent tuberculosis. In the same patient from time to time we have observed a change in the type of acid-fast rods present in the sputum correlated with changing signs and symptoms. (Tables I and II).

Utilizing the technic for the cultivation of tubercle bacilli in single colonies first described by Petroff we have cultured the sulphuric acid or sodium hydrate digested sputum from each of the cases here studied every second week, alternating this examination with the phosphatide precipitin test on the blood serum. Two distinct colony types have been thus far quite sharply differentiated, corresponding to the types of organisms found in the direct staining of the sputum. Finely granular, low, spreading, cream-colored colonies ("S" types), with or without a veil-like halo of growth surrounding them, have predominated in all the fatal cases within the last two to four months of life. Large, pyramidal, rough, ridged, chromogenic colonies ("R" type) have dominated in the more chronic stationary cases. Certain "transition" colonies showing some of the characteristics from each of the above colony types have appeared in the cases showing the typical "S" forms. Also, very fine, opaque, droplet-like colonies consisting of very short, granular, acid-fast bodies, have appeared on the plates from

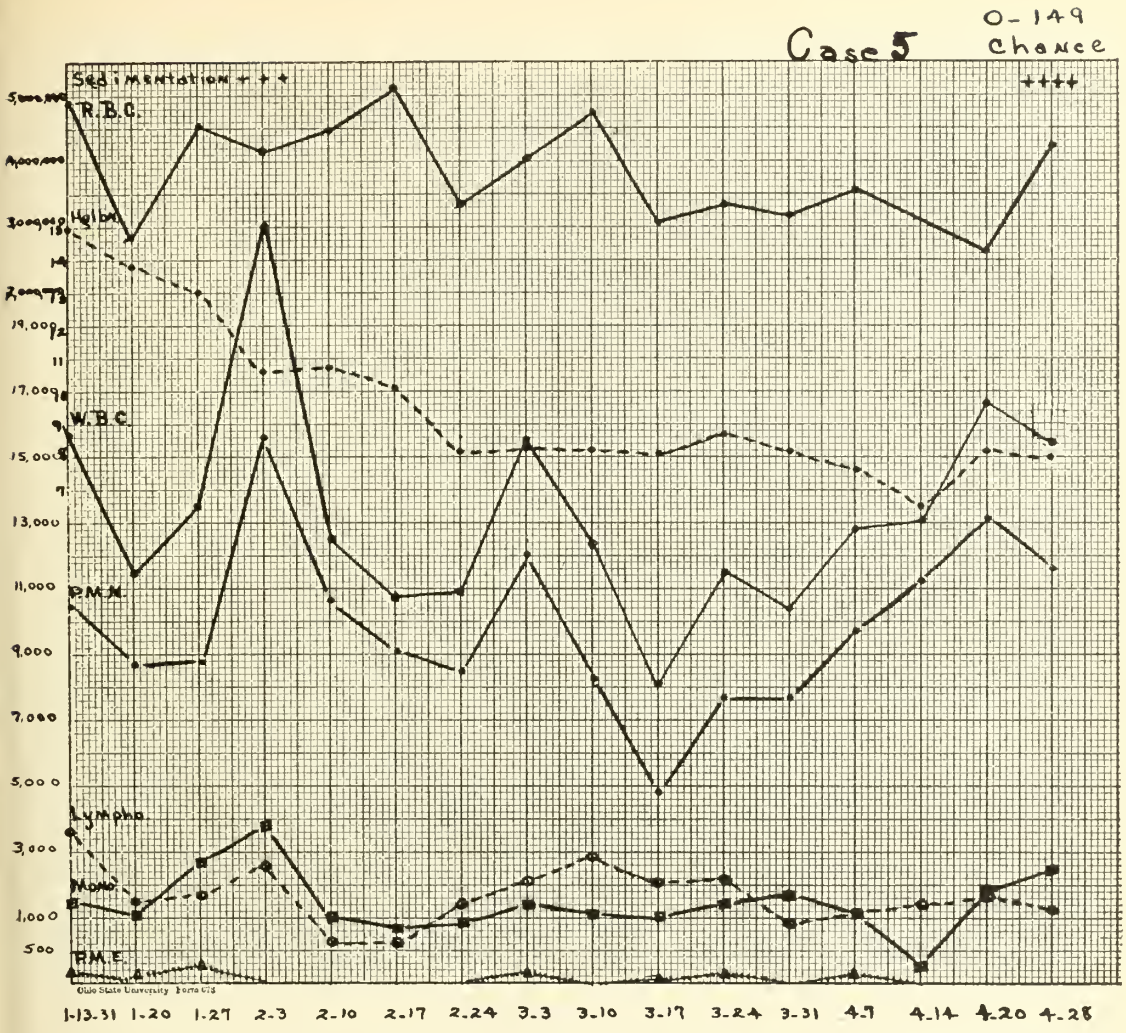


Chart 2. Chronic pulmonary tuberculosis with exacerbations and remissions. The progressive development of a secondary anemia of low color index is shown. The rise in total leucocytes during January with disappearance of eosinophils and a reversed M/L index mark a period of relapse, spread of new foci and increased expectoration indicative of a breakdown of tissue. This was followed by clinical improvement ushered in by falling neutrophils and monocytes, a reappearance of the eosinophils and a definitely lowered M/L ratio during March. A second exacerbation of the disease occurred in April. The erythrocyte sedimentation rate increased during the period of observation. X-rays of the lungs remained essentially unchanged. These studies reveal the varying success which from time to time attends the fight of the body to control the tuberculous disease process.

case No. 2. Further bacteriological studies are in progress to ascertain the pathogenicity of each colony type and to study further dissociation phenomena on artificial media.

THE BLOOD

From many angles the blood lends itself to investigation in tuberculosis. Perhaps the best known test is that of the erythrocyte sedimentation. While not specific for tuberculosis, it nevertheless performs a valuable service in following the progress of the disease. Using the Wintrobe tube, we have chosen arbitrarily to designate the normal sedimentation rate as +. Deviations from the normal are designated ++, +++, or ++++, depending upon the sedimentation velocity of the red blood cells as evidenced by the type of curve obtained during the first hour, a fall approaching the vertical being designated as ++++. The severely ill patients have all shown a maximum fall in one hour. An occasional patient, as for example case No. 11, shows a + + + + sedimentation curve with all other data relatively less unfavorable. In such an instance great care should be exercised in relaxing vigilance with respect to bed rest. With general clinical improvement and regressive lesions the sedimentation rate usually tends to return to normal.

The red blood cells seldom show more than a very slight reduction in total numbers in tuberculosis, except in the terminal stages. However, the studies in this series of cases point to a much more rapid fall in the hemoglobin content of the blood with a consequent lowering of the color index. Cases 3, 4, 5, 6 and 8 demonstrate par-

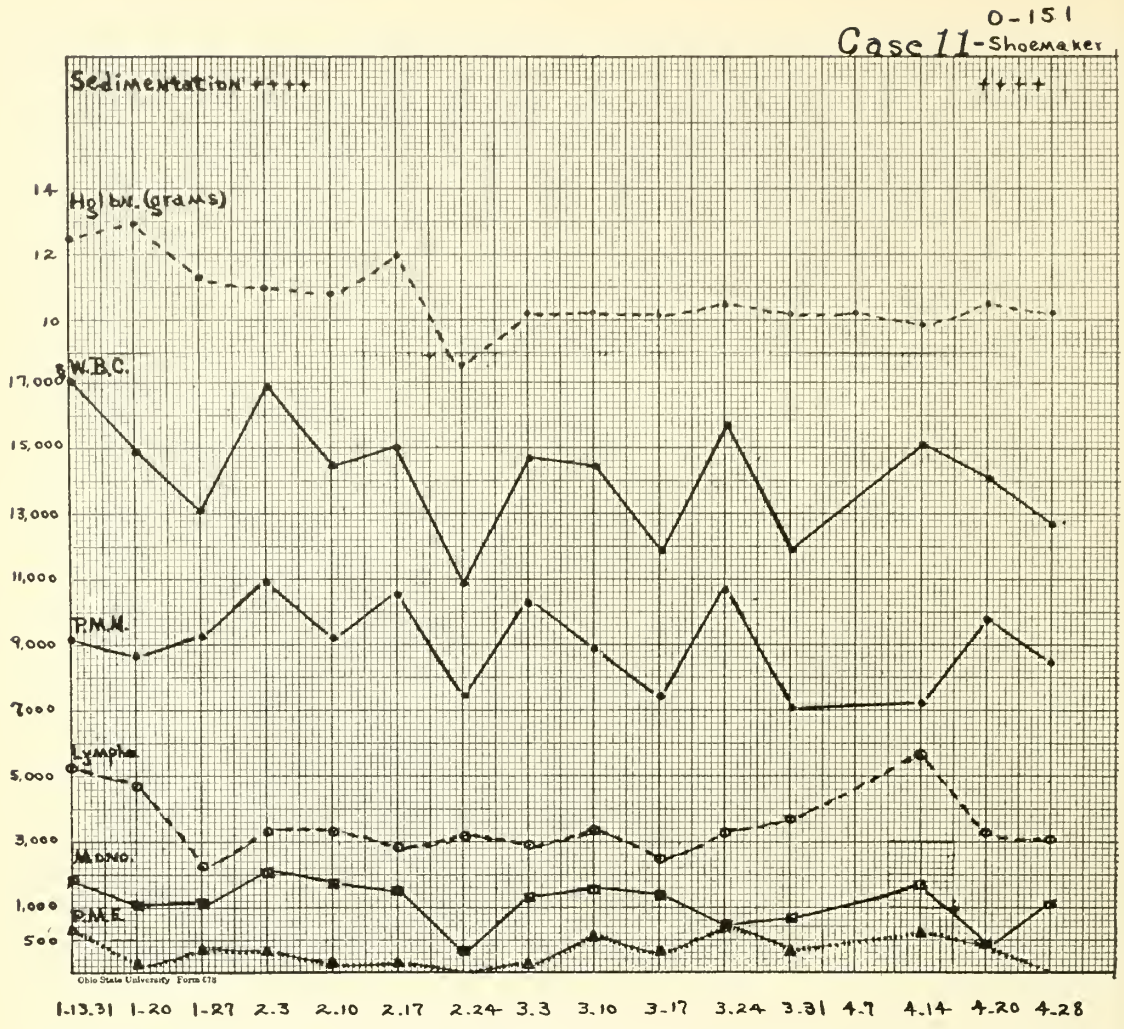


Chart 3. Far advanced pulmonary tuberculosis with good resistance to active spread so long as bed rest is rigidly continued. The low M/L index and the eosinophilia represent favorable prognostic signs. The first two months show more activity than the last two.

ticularly the rapid drop in hemoglobin over a four months period.

However, it is the count of the white blood cells in tuberculosis which is of primary interest at the present time. The discovery by Sabin, Doan and Cunningham[1] in 1925 of the relationship which exists between the monocyte of the circulating blood and the epithelioid cell of the tubercle forms the basis for the recently increased interest in the cellular mechanism of this disease. Cunningham, Sabin, et al.[2] first showed in experimental tuberculosis the importance of the monocyte-lymphocyte ratio as obtained from differential counts of the circulating blood. They pointed out that progressive tuberculous lesions in the tissues were reflected by a gradually increasing monocyte and a decreasing lymphocyte count, while regressing lesions were accompanied by a reversal of these relationships, that is by a lowering of the M/L index in the blood (normal 0.33). Qualitative changes in the monocytes, with the appearance of epithelioid cells in the peripheral blood, best seen and identified in supravital preparations[3], are quite as significant as the quantitative changes just mentioned.

Medlar[4] has emphasized the importance of the neutrophilic leucocytes in appraising the incipiency and extent of caseation and cavitation in tuberculous foci. Wiseman[5] recently re-evaluated certain qualitative changes in the lymphocyte with reference to age and maturity, which when applied to the study of these cells in tuberculous cases further aids in the analysis and prognosis of the disease. Wiseman has found the normal average lymphocyte formula to be 5 per cent young basophilic types, 45 per cent mature moderately basophilic forms, and 50 per cent old, faintly basophilic lymphocytes. It will be seen from Table I that only cases 11 and 12 show an approximately normal lymphocytic formula. In tuberculosis, the increase in young, immature forms denotes an additional strain placed on the

Patient	Age (in years)	Sex / Race	Probable Duration of Disease	1931	Temperature	Pulse	Weight (in lbs.)	X-RAY: Extent of pulmonary lesions.	Sputum: Gaffky	Sputum: Quality	Sputum: Culture Colony Types
Case No. 1 *J. S.	17	M. W.	9 mos.				138 (Ave. Norm.)				
				Jan.	97.6°–101.6°	92–100	118	F.A.–C	IX	Long, thin Not Clumped	Flat "S" only
				Feb.	94.0°– 96.0°	90– 98	85	" "	VIII	"	
Case No. 2 *M. Y.	20	F. C.	15 mos.				142 (Ave. Norm.)				
				Jan.	96.0°–103.0°	90–128	94	F.A.–C	IX	Long, thin Scattered	Occasional "R" Many "S" with halo
				Mar.	94.0°– 98.0°	100–140	75	" "	IX	"	
Case No. 3 *J. T.	20	F. W.	2 yrs.				108 (Ave. Norm.)				
				Jan.	98.0°– 99.0°	84–110	99	F.A.–B	VII	Mod. thick, Long, Scattered	3 Types: "S", Transi-tional, Opaque
				Mar.	98.0°– 99.0°	120–150	85	" –C	VII	"	
Case No. 4 M. B.	18	F. W.	3 yrs.				100 (Ave. Norm.)				
				Jan.	97.0°– 99.4°	90–104	83	F.A.–B	II	Mixed, Pleomorphic	1 "R" to 3 "S"
				May	95.0°– 97.0°	110–130	75	" –C	"	"	
Case No. 5 W. C.	19	M. W.	2½ yrs.				118 (Ave. Norm.)				
				Jan.	98.2°– 99.2°	90–100	110	F.A.–C	IV	Long, thin Scattered	Many "R" Chromo-genic, and "S."
				May	99.0°–102.0°	108–136	85	" "	"	"	
Case No. 6 R. A.	19	M. W.	8 mos.				138 (Ave. Norm.)				
				Jan.	99.0°–102.0°	94–106	128	F.A.–C	IX	Thin rods Clumped	1 pos. plate 4 colonies "T"
				May	98.0°–102.0°	92–120	123	" "	"	"	
Case No. 7 H. D.	21	M. W.	7 yrs.				130 (Ave. Norm.)				
				Feb.	98.0°– 98.6°	82– 90	129	F.A.–A	Neg.	Neg.	Neg.
				May	97.4°– 98.6°	84– 92	128	" "	"	Neg.	
Case No. 8 W. I.	22	M. W.	3 yrs.				175 (Ave. Norm.)				
				Jan.	98.0°– 98.6°	90–100	143	F.A.–C	IX	Short, thick Clumped	Many "R" Few "S"
				May	98.0°– 99.0°	92–110	141	" "	"	"	
Case No. 9 P. T.	18	M. W.	1¾ yrs.				130 (Ave. Norm.)				
				Jan.	97.8°– 98.6°	92–100	137	F.A.–A	Neg.	"	Many "R" only
				May	97.0°– 98.0°	96–100	160	" "			
Case No. 10 J. W.	50	M. W.	5 yrs.				125 (Ave. Norm.)				
				Jan.	96.0°– 98.0°	72– 80	128	F.A.–A	Neg.	Neg.	1 pos. plate 4 colonies "T"
				May	97.0°	80– 84	131	" "	"	Neg.	
Case No. 11 V. S.	18	F. W.	4 yrs.				90				
				Jan.	97.4°– 98.2°	76– 88	82	F.A.–B	VIII	Severe	Neg.
				May	97.6°– 98.4°	76– 84	84	" "	VII	"	
Case No. 12 R. N.	26	F. W.	6 yrs. (Hem.)				106 (Ave. Norm.)				
				Jan.	98.0°– 99.0°	76– 84	129	M.A.–A	Neg.	Neg.	1 pos. plate 3 colonies "R"
				May	98.0°– 98.6°	72– 84	139	" "	"	"	

Patient	Blood							
	Erythrocyte Sedimentation Rate	Total R. B. C.	Hemoglobin (grams per 100 cc blood)	Total W. B. C.	P. M. N.	M/L Index	Lymphocyte Formula	Phosphatide Precipitin Test
Case No. 1 *J. S.	Not Done	4,200,000	8.8	10,100	(66%) 6,700	0.61	59-18-23	Not Made
	" "	3,800,000	7.3	8,800	(73%) 6,400	2.33	33-66- 0	" "
Case No. 2 *M. Y.	Not Done	3,000,000	6.7	12,750	(68%) 8,670	1.00	40-60- 0	1-20
		2,470,000	6.9	25,000	(61%) 15,280	1.30	16-84- 0	1-40
Case No. 3 *J. T.	++++	5,300,000	14.8	10,000	(69-84%) 8,800	0.72-1.50	41-52- 7	1-40
	+++++	4,600,000	10.2	15,000	(84%) 12,500	1.50	56-22-22	1-80
Case No. 4 M. B.	++++	5,190,000	14.6	13,000	(75%) 12,000	0.90-1.62	42-33-25	1-40
	++++	5,370,000	11.8	31,900	(87%) 27,000	2.25	36-64- 0	1-20
Case No. 5 W. C.	+++	4,900,000	15.0	15,000	(67%) 10,500	0.39	11-58-29	1-1280
	++++	4,200,000	8.0	15,000	(75%) 11,600	2.00	25-44-31	1-160
Case No. 6 R. A.	+++	4,500,000	15.0	16,000	(58%) 9,400	1.5	28-67- 5	1-320
	++++	3,360,000	10.7	21,500	(73%) 15,700	2.57	34-66- 0	1-640
Case No. 7 H. D.	++	5,860,000	13.9	11,900	(77%) 9,200	0.63	50-41- 9	Not Made
	++	3,790,000	11.3	9,500	(80%) 7,600	1.00	18-41-41	" "
Case No. 8 W. I.	+++	6,000,000	16.0	8,500	(70%) 5,900	0.23	41-55- 5	1-1280
	++++	5,000,000	9.8	12,500	(80%) 10,000	0.40	33-42-25	1-2560
Case No. 9 P. T.	++	5,280,000	13.9	11,500	(77%) 8,800	0.31	50-46- 6	1-1280
	++	5,300,000	12.3	8,500	(75%) 6,300	0.60	30-40-30	1-20
Case No. 10 J. W.	+++	5,400,000	14.6	11,000	(66%) 7,350	0.22	32-64- 4	1-640
	+++	5,200,000	12.8	9,000	(68%) 6,200	0.42	36-32-32	1-40,000
Case No. 11 V. S.	++++	5,180,000	12.5	17,000	(54%) 9,200	0.35	11-53-34	1-640
	++++	4,200,000	10.2	12,000	(67%) 8,500	0.40	18-41-41	1-160,000
Case No. 12 R. N.	++	4,400,000	11.8	7,400	(52%) 3,800	0.30	7-44-48	1-5,000
	++	4,350,000	10.4	9,400	(61%) 5,700	0.20	7-40-53	1-10,000

lymphatic tissues. It has long been recognized[6,7] that resistance to tuberculosis is associated with a relative lympocytosis, but it is also essential that the lymphocytes be relatively mature to subserve their function. Thus, in known tuberculous patients, if the total lymphocyte count is relatively low, with a degenerative rather than a regenerative "shift to the left", the prognosis is grave, even though the M/L index may not be markedly increased.

The present study only adds a small increment to the rapidly growing list of published cases[8,14] in which a careful study of the blood has proved to be a most sensitive index for following the tuberculous patient.

PHOSPHATIDE PRECIPITIN TEST

The correlated biochemical studies which have been pursued under the direction of the Research Committee of the National Tuberculosis Association during the past five years have very materially advanced our knowledge of the chemical structure of the tubercle bacillus and the biological significance of its various chemical fractions. The lipoids, more particularly the phosphatide and liquid saturated fatty acids, isolated by Doctor R. J. Anderson of the Sterling Chemistry Laboratory, Yale University, have been shown in studies at the Rockefeller Institute[15] to be primarily responsible for tubercle formation. Further studies[15] have indicated that the phosphatide has antigenic properties and that the sera of animals differ in their ability to neutralize or precipitate this product when tuberculosis exists. Utilizing these observations, a precipitin test has been devised[14] by which an assay is made of the power of various suspected tuberculous fluids—blood serum, spinal fluid, pleural exudate, peritoneal or joint fluids—to flocculate the phosphatide antigen. In applying this test to the present series of cases it will be observed that in the terminal phases of the disease, represented by the first four cases, the titre of the blood serum was very low. Certain of the other cases, notably those which have been either not progressing or definitely improving, have shown a very high precipitating titre for the phosphatide. Thus, we feel that such a test gives data of definite prognostic value, and is indicative of the status of certain serologic defense mechanisms in the tuberculous body, just as the quality and relative number of the various white cells of the blood are significant of the effectiveness of its cellular defenses.

TREATMENT

The majority of the procedures mentioned above will be seen to yield data of prognostic significance and thus are of importance in evaluating the success or failure of any method of treatment instituted in the individual tuberculous patient.

Once a diagnosis is made or strongly suspected, absolute bed rest, with a high vitamin diet is indicated. Supplementing a well-rounded, wholesome, fresh vegetable and meat dietary, it may be well to give ½ oz. of cod liver oil layered over 3 oz. of tomato juice, served ice-cold in a tumbler three times a day, immediately after each meal.[16] A careful study along the lines above outlined will determine within two months the effectiveness of this regimen. Repeated blood studies will provide the most important single evidence for determining the future course of treatment. If a "septic" leucocyte picture or increasing M/L index is observed, collapse therapy, unless otherwise counterindicated, should be instituted.[13] When effectively maintained collapse does not bring material benefit within six months, pneumolysis, phrenicectomy, or in some cases, thoracoplasty should be considered.

SUMMARY

In addition to *X*-ray studies, the value of which in the diagnosis and follow-up of tuberculous patients is unquestioned, we have made certain supplementary observations which have also

TABLE II

QUALITATIVE CHARACTER OF ACID-FAST BACTERIA IN SPUTUM OVER 3-YEAR PERIOD.

Case	1929		1930				1931					
	Aug.	Oct.	Feb.	June	July	Nov.	Jan.	Feb.	Mar.	Apr.	May	
No. 3						"R"	"T"				"S"	
No. 4		"R"	"R"		"S"	"S"	"S"		"S"			
No. 5	"R"			"R"				"S"				
No. 8			"R"			"S"			"S"	"R"		

"R" indicates thick, clubbed, spore-bearing rods, strongly acid-fast, *in clumps*.
"S" indicates thin, pleomorphic, faintly acid-fast rods, scattered singly.
"T" indicates mixture of "R" and "S."

yielded important information. Among these a careful differential study of the white cells of the circulating blood usually has proved to be a very sensitive index of the extent and progress of tuberculous lesions. Carefully prepared blood films stained with one of the Romanowsky dye combinations, such as Wright's or Giemsa stain, will provide adequate criteria for differentiating the several types of white blood cells. The weight curve, the hemoglobin, and the qualitative studies of the white blood cells have reflected most sensitively the clinical course of tuberculosis in the present series of cases. Much of the virtue of the particular type of observation will reside in the care with which it is made and the number of such observations which are at hand. The prognosis and direction of adequate treatment are largely dependent upon a series of observations on the same patient carefully and accurately made.

DISCUSSION

C. O. PROBST, M.D., Columbus: My part in the discussion of this excellent presentation of a most interesting subject will be from a utilitarian standpoint. That is, how to bring this new information to our patients.

Dr. Doan has been closely identified with the study that has been made in recent years of certain changes that take place in the blood, especially in the white blood cells, in tuberculosis. A sufficiently large number of cases have been studied to give us assurance of the value of this method. I take it that a much larger number of cases must be studied to determine whether the test will not fail in a certain percentage of tuberculous patients.

The diagnosis of early tuberculosis in adults is still a matter of difficulty in many cases, and much more difficult in children. At the meeting of the Climatological and Clinical Association, Dr. Lawrason Brown of Saranac, reported a study of 500 cases of tuberculosis in which there were no or indefinite physical signs. If we can be given some new and reliable diagnostic test which will materially decrease our failures in recognizing tuberculosis in its early, curable stage, it will be another medical victory of great importance.

Such a test must be either one that the modern trained physician can easily carry out himself, and with accuracy, or the blood specimen must be preservable for a sufficient time to reach a properly manned laboratory. I understand that in the studies now being made by Dr. Doan quantitative and qualitative changes in the blood cells must be observed at once; and furthermore, that highly developed technique is necessary. It would be possible, of course, funds permitting, to attach men of sufficient training to our sanatoria for work of this kind, but thousands never reach the sanatorium.

A recent article by Medlar and Pesquera on "the leucocytic reaction in tuberculosis" describes a method that does not require an immediate cell count. It may be less accurate. I hope Dr. Doan will tell us about this. They distinctly state, however, that it is not diagnostic for tuberculosis.

It seems probable that if this test is fully established and becomes general, its greatest value will be prognostic, and especially in guiding us in deciding upon certain surgical measures now becoming more and more frequent in the treatment of tuberculosis. Dr. Doan suggests that a patient, who, after two months with ordinary methods of treatment fails to improve or retrogrades, as shown by blood studies, should be given some form of collapse. Again, in a case undergoing air compression, it would give us much earlier and more reliable information of a breaking down of the contralateral lung. A fresh invasion of tubercules would be heralded well in advance of clinical symptoms or physical signs.

I am especially pleased that Dr. Doan's latest work along this line is being carried on at our own County Sanatorium, and I feel greatly indebted to Dr. Doan. Possibly greater use could be made of the various sanatoria in Ohio for worthwhile research work in trying to solve some of the many problems still encountered in the cure and prevention of tuberculosis.

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—Miss Mary A. Jamieson, Columbus, superintendent of Grant Hospital, was elevated to the presidency at the annual meeting of the Ohio Hospital Association held at Akron the week of March 14. B. W. Stewart, Youngstown City Hospital, was named president-elect. Other officers are: C. E. Findlay, Springfield City Hospital, first vice president; Sister M. Carmelita, St. John's Hospital, Cleveland, second vice president; Rev. M. F. Griffin, Cleveland, treasurer, and John R. Mannix, Cleveland, executive secretary.

—Ira L. Dodge, for the past three years superintendent of the Marietta Memorial Hospital, has been appointed superintendent of the new Huron Road Hospital, Cleveland.

—Dr. Richard F. McKean of the Detroit Receiving Hospital conducted a clinical lecture at the Detwiler Memorial Hospital, Wauseon, on March 17, on the classification and treatment of diabetes. Forty-five attended the conference, the fourth of a series of monthly clinics at the hospital.

Swelling of The Eyelids in Patients with Hypothyroidism

H. B. WEISS, M.D., and CLARENCE KING, M.D., Cincinnati, Ohio

SWELLING of the eyelids is a common symptom frequently seen by both the opthalmologist and the internist. The cause may not be obvious and often is difficult to diagnose. At times the finding is incidental to a routine examination but there is a group of patients that present themselves with this symptom as their chief complaint.

The following patient is a striking example: About three years ago, a woman presented herself with the complaint that she had swelling of the eyelids. She had had this for some time; it was worse in the morning. She had been told that it was due to sinusitis. In the morning the swelling had been so marked that it was necessary for her to open her lids with her fingers in order to see clearly. She had not had any illness except for frequent colds and sore throats, with recurring attacks of sinusitis. She had had some slight dyspnea on exercise. There was no precordial pains, no cough, no edema elsewhere and no urinary disturbance. Her appetite and digestion had been good and she had not been constipated. She was married; her husband and two sons were living and well.

The examination showed a woman of 58 years, not overweight and somewhat short. There was marked swelling of the lids, especially the upper lids, of both eyes. The nasal mucus membrane was dry, the neck was normal, and the thyroid was not enlarged. Her heart was not enlarged; the sounds were clear, rate 72, regular, and the second aortic sound was accentuated. The blood pressure was 200/110. The fluoroscopic examination showed the heart to be normal in size, shape and position. The aorta was somewhat dilated. Two specimens of urine did not reveal any abnormalities, except for a few pus cells. The kidney functional tests were within normal limits.

The patient was seen off and on during the next two years without very much change in her condition. In January of 1930 she had a hemorrhage following the extraction of several teeth, but this subsided quickly. The heart rate at this time was 66, blood pressure 210/100. Later she had more teeth removed without any difficulty. She developed constipation, ringing in the ears, and the edema of the lids persisted. It was at this time that a basal metabolic reading estimation was made, and the two readings were minus 24 and minus 26. The patient was then given small doses of thyroid extract and after several weeks she felt much better, the swelling of the lids had diminished greatly, though it did not disappear entirely, and her headaches and nervousness had been greatly relieved. Her blood pressure dropped to 150/80. She was not constipated, and there was a loss of four pounds in weight, since taking the thyroid extract. At this time the thyroid extract was stopped and two weeks later she returned with a gain of three pounds, and had an increase in the swelling of the lids, which began approximately one week after the cessation of the thyroid extract. The swelling was more marked in the morning; there was a return of the nervousness and restlessness. The blood count did not reveal any abnormalities except for a slight anemia. A sugar tolerance estimation was within normal limits. The urine again was clear.

The patient was again placed upon thyroid extract and was observed from time to time. The swelling of the lids did not disappear entirely. Whenever she had recurrences of a cold, there was a tendency for the swelling to become more pronounced. If she stopped the thyroid extract, the swelling of the eyelids had a tendency to increase. This has been partially controlled from time to time with thyroid extract.

Observing this patient led us to look for similar patients and to our surprise we found they were quite numerous. In the past few months we have seen twenty-six patients with various degrees of swelling of the lids, usually characterized by a diminished basal metabolic reading. Though it has long been known that swelling of the lids may be present in myxedema and other hypothyroid states, very definite attention has not been called to this symptom. Beach[1], in reporting a patient with an erysipeloid infection of the face, producing swelling of the lids, gave a classification modified from Fuchs, including many conditions both local and systemic that may produce this swelling.

It is not necessary to enter into a discussion of classification at this time, but perhaps it may be worth mentioning some of the common causes associated with swelling of the lids. Inflammatory causes are common. These may be local or generalized. The patient may be sensitive to a foreign protein, as food, bacteria, or an inhaled protein as in hay fever. Swelling of the lids has been associated with infection of the teeth. It is well known that hydremia of the lids may be found in patients who have nephritis and cardiac failure. In general, swelling of the lower lids is seen more commonly and it is said to be due to the laxity of the tissues, allowing for the ready accumulation of fluid. Obviously, swelling of the lids may be due to local venous or lymphatic obstruction.

Read before the Eye, Ear, Nose and Throat Section, Ohio State Medical Association, at the 85th Annual Meeting, Toledo, May 12-13, 1931.

From the Departments of Medicine and Ophthalmology, Medical College, University of Cincinnati.



Patient No. 1
B. M. R.—24—26



Patient No. 2
B. M. R.—11—6



Patient No. 3
B. M. R.—2—5

Pathologists[2] find that the swelling in hypothyroidism is associated with a variable increase in connective tissue as well as water retention. We can expect that treatment can influence the water retention but obviously changes in the connective tissue would be limited.

In this series of patients we have found various degrees of swelling of the lids, mostly of the upper, often in the lower, but seldom of both. Sexton[3] mentioned that "in myxedema there is a tendency for the eyes to appear smaller because of the circular infiltration about them."

Lorand[4] in a recent study points out the similarity of hypothyroidism to senility. He believes that the degeneration of the thyroid may lead to atrophy of other organs, perhaps accounting for some of the symptoms found in patients with hypothyroidism.

Warfield[1] in reporting a series of patients with hypothyroidism found it more commonly at the beginning and cessation of the menstrual function. There are a few symptoms that are very suggestive of depressed thyroid activity or hypothyroidism, such as undue fatigue, headaches, drowsiness, rheumatoid pains and constipation. The menstrual periods may be irregular; the patients are susceptible to cold weather; they often have difficulty in keeping their weight within reasonable limits, even with dietary discretion. Nevertheless, patients with hypothyroidism may not be heavy, since it has been frequently found in thin and underweight people. It is important to note that the physical findings are significantly lacking.

In our series of patients there has been one common physical finding; that is, the swelling of the eyelids, notably the upper lids. We have seen patients who are underweight, as well as overweight, with ages ranging from eighteen to fifty-nine years. Many have the common symptoms mentioned by Warfield. In this group of twenty-six patients only four were male. Twenty-five (25) per cent were underweight and about thirty-five (35) per cent were overweight. About one-half of them were subject to headaches and about one-third of the women had passed through the menopause. Two had menstrual irregularities. Associated with the swelling of the eyelids only five had edema of the feet from time to time, three had edema of the hands, and very few had edema elsewhere. Of this group six had had operations on the thyroid. Four patients, three of whom had had thyroidectomies, had also received *X*-ray therapy. There were no remarkable cardiovascular symptoms; the pulse was often slow; the blood pressure most often was within normal limits. The basal metabolic readings were variable, as low as minus 36. The majority had readings from minus 10 to minus 20, and a few were within normal limits though on the minus side.

An important part of the examination is obviously the basal metabolic reading, because of the indefiniteness of the history and the paucity of the physical findings. A slight variation may often be difficult to interpret but it is felt that the information given by a small minus rate is of greater value than a moderately increased rate.[5]

In the study of these patients other laboratory data did not give significant information. There were no anemias, no evidence of remarkable kidney changes, nor did the patients have any evidence of organic heart disease.

Swelling of the upper lids was very prominent in those patients who developed hypothyroidism following thyroidectomy, especially when associated with *X*-ray exposure to the thyroid, either before or after the operation. The combination of thyroidectomy and *X*-ray therapy seemed to predispose the patient to hypothyroidism.



Patient No. 5
B. M. R. 29 and—24

When the diagnosis of hypothyroidism was established, the patient was given thyroid extract or thyroxin. There has not been found a direct relationship between the degree of a depressed basal metabolic reading and the amount of thyroid extract necessary to bring it back to normal. Every patient is a law unto himself. Doses of six to nine grains of the extract have been advised but in our experience, smaller doses, usually from one to six grains per day, have been sufficient. The more marked the swelling of the eyelids the more readily does the patient seem to respond. Slight changes in the degree of swelling are not readily detected, probably influenced by the amount of connective tissue present. This factor may also affect the response to therapy, which we soon realized would not be uniform. However, it is



Patient No. 6
B. M. R.—9 —10

interesting to note the improvement of the subjective symptoms.

The patient feels that she can open her eyes more easily and often reports that the eyelids do not feel as heavy as previously.

There are certain familial types of prominent upper lids that may be confusing. Redundant folds of skin or a prominent supra-orbital ridge may simulate swelling. These may be difficult to differentiate from swelling of the soft tissues, so a complete history and examination, including one or more basal metabolic readings, may be necessary.

In addition to the change of the upper lids, there have been other noteworthy results of the treatment. An increased blood pressure has dropped in a few patients; many patients with a hypotension have had a rise in blood pressure and several have reported less nervousness. There may be less fatigue; the constipation seems less obstinate, and there is, as one would expect, a general improvement in well-being.

It seems timely to present this report because of the frequency with which patients with swelling of the lids present themselves. An obvious cause cannot always be found, but it is well to keep in mind that the swelling of the lids, especially the upper lids, may be the only physical finding that eventually will lead to the diagnosis of a mild or a severe hypothyroidism.

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Annual Reunion of Cincinnati College of Medicine Alumni, June 10-11

Dr. Dudley W. Palmer of the class of 1906, College of Medicine, University of Cincinnati, and president of the Alumni Association of the College of Medicine, with a strong committee to assist him, is making extensive plans for the next reunion and home-coming of the association on Friday and Saturday, June 10 and 11.

Dr. Ray Lyman Wilbur, Secretary of the Interior and former president of the American Medical Association, has been invited to make the principal address at the annual banquet to be given on Friday evening, June 10. There were almost 400 at last year's banquet and the goal for this year's affair has been set at 500.

Many new developments at the university will serve as an added attraction to those who have not been back to the campus for some years, including the new Children's Hospital and Research Building, the Kettering Laboratory, the new Out-Patient Dispensary, the Holmes Memorial Hospital, the Tuberculosis Sanatorium and the hospital for the chronic sick.

Officers and committees of the Alumni Association who are completing the plans for the 1932 gathering are:

President, Dr. Palmer; vice president, Dr. Alfred Friedlander; secretary, Dr. Robert H. Kotte; banquet and music, Drs. William Abbott, Ralph Good and William Doughty; speakers, Drs. Friedlander, A. C. Bachmeyer, Mont R. Reid and Charlotte W. Schell; golf, Drs. Louis Feid, Jr., and Harry Box; program, Drs. Parke Smith, J. Louis Ransohoff, Ben Bryant, Stanley E. Dorst and Helena Ratterman; class reunions, Drs. Henry Freiberg, J. L. Tuechter, Fred Heinold and J. C. Oliver; publicity, Drs. Carl Wilzbach, F. C. Cross and Martin H. Fischer.

Evaluation of Tonsils

JAMES G. KRAMER, M.D., F.A.C.P., Akron, Ohio

EVALUATION of tonsils is probably the most frequent and important problem confronting the pediatrician and as yet we have no set established critera or standards with which to judge them. One extreme recommends the removal of all tonsils, the other advises universal retention.

It is mystifying at times to see some physicians glance in a throat and render judgment upon tonsils therein. When attempts are made to obtain their reasons for the verdict, invariably the answers are vague and evasive. There is no panacea to offer you, the only hope is to call your attention to the physical examination of the tonsils, which at present is being ignored.

A carefully obtained history is just as significant in the proper evaluation of this organ as it is in all general medicine. Tonsillar hypertrophy and infection are distinctly family traits. When one has had the opportunity of examining family groups as I have had on their admission to a children's home, the similarity of the lymphatic deposits in the nose and throat of these groups is striking, and it is surprising how certain infections will invade one family group and skip another.

The following incidents in the past and present history are also of value in judging tonsils: Frequent nose and throat colds, recurring tonsillitis, nasal obstruction with mouth breathing, repeated attacks of otitus media, chronic otitus media, prolonged or intermittent cervical adenitis, chronic sinus infection, general malnutrition or systemic diseases such as rheumatism, myositis, chorea, iritis, nephritis, arthritis and carditis, which are known to result from a foci of infection in the throat.

Evidence from history alone is rarely considered of sufficient importance to advise surgery without confirmatory finding in the physical examination. A complete physical examination is as necessary in the evaluation of tonsils as it is in every other condition in infancy and childhood. The finding of disease in the ear, nasal sinuses or glands of the neck might well be taken as additional evidence in the condemnation of tonsils. The presence of an enlarged gland under the angle of the jaw peering forward under the anterior border of the sterno-mastoid muscle is accepted by many as definite proof of disease in the body of the tonsil.[1]

The examination of the tonsil and its contents is of paramount importance and if this is to be done properly the old-fashioned head mirror should be used. This leaves both hands free to manipulate the parts to be examined. I admit that it is almost impossible to use the head mirror and reflected light in the average house to house practice. However, this method is one of choice for office work where one is called upon more often to see other than acute disease.

On looking into the throat, depressing the tongue with a wooden blade in one hand, you look directly at the surface of the anterior pillars and view some of the lateral surface of both tonsils. Any reddening or swelling of the anterior pillar or plicae triangularis is a definite diagnostic sign of inflammatory disease beneath the reddened area. Small white abscesses or collections of tonsillar exudate may sometimes be seen through the pillars.

A further complete view of the lateral face of the tonsil may be obtained by rotation, which is very easily accomplished by applying another tongue blade to the anterior pillar as close to the free margin as possible. (Fig. I). A lateral movement of the blade towards the buccal wall relaxes the anterior pillar and stretches the plicae triangularis. Having accomplished this, firm pressure is now exerted against the body of the tonsil. The lateral face now presents and exposes the crypts with their inflammation, exudation, scarring or contracture.

The normal tonsil is a mass of lymphatic tissue held in shape by successive layers of areolar tissue situated in the sinus tonsillaris, a recess in the lateral wall of the throat. This lymphatic tissue is pierced by numerous crypts, some straight, others branching and extending from the surface of the tonsil to the capsule[2]. Normally these crypts do not contain any macroscopic material.

The tonsil is surrounded on three sides in its snug recess by muscle tissue. The outer wall of

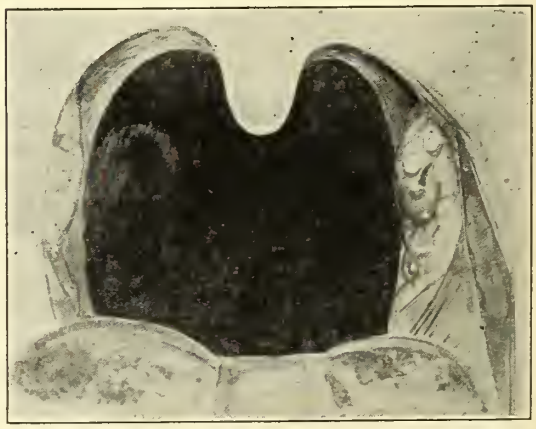


FIGURE I. Shows tongue blade rotating and compressing the tonsil. Tonsillar exudate can be seen coming from the crypts.

Read before the Section on Obstetrics and Pediatrics, Ohio State Medical Association, at the 85th Annual Meeting, Toledo, May 12-13, 1931.

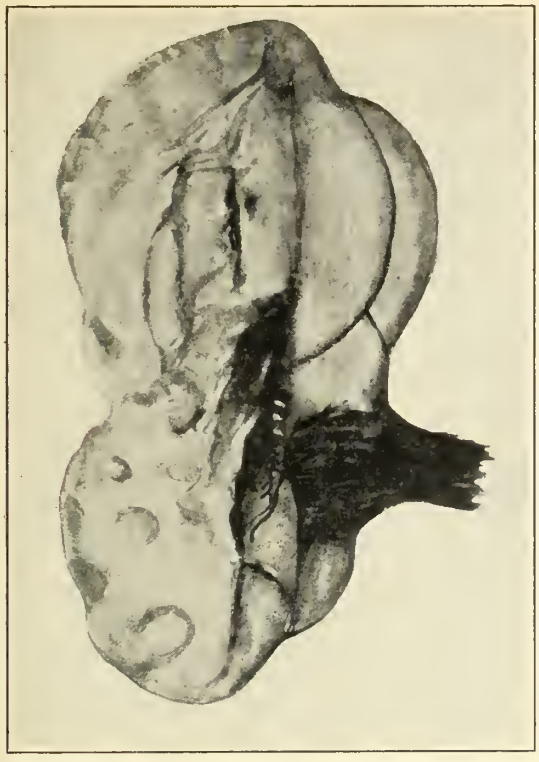


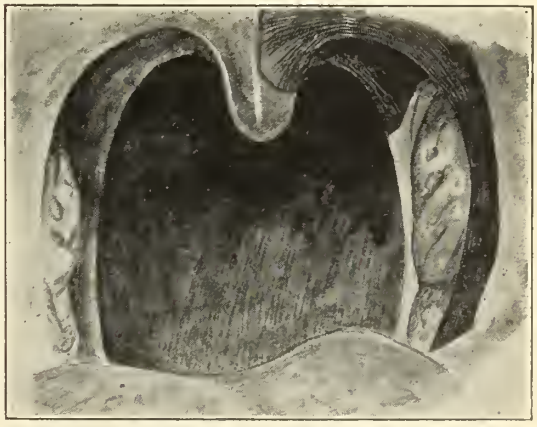
FIGURE II. Lateral view of an excised tonsil showing the attachment of the Tonsillopharyngeous Muscle.

the sinus tonsillaris is composed of the superior constrictor muscle above and the palatopharyngeous muscle below, some fibres of the latter muscle become attached as a transverse band to the central body of the tonsil and have recently been described as the tonsillopharyngeous muscle by Todd and Fowler.[3] (Fig. II). The anterior pillar which makes up the anterior face of the sinus is composed of the palato-glossus muscle, while the posterior pillar composed of the palato-pharyngeous muscle, is the posterior boundary. These three muscles incase the tonsil from all sides except the exposed lateral internal surface. (Fig. III).

These muscles have a distinct physiological effect on the tonsil in that they tend to continually evacuate the crypt contents of the normal tonsil. This can best be seen in babies and young children before tonsillar disease has caused adhesions and contractures which spoil the normal function. In some cases the pillars seem to grip the tonsil as it is pulled toward the lateral wall presumably by the tonsillo-pharyngeal muscle. In other cases the pillars contract on a tonsil that is merely held firmly in place by the tonsillo-pharyngeal muscle. I do not wish to convey the impression that this contracture in any way resembles a vise, but rather continued gentle pressure and massage which has a tendency to milk out the crypt contents.

Some authorities[4] maintain that exudate in tonsil crypts is not always pathological. This group, interesting enough, are practically all laboratory workers who have been denied the privilege of following the changing tonsil from the acute disease to the chronic state. The clinical observation of the transition of the tonsillar tissue and exudate through the different stages of involution should illuminate and convince one that exudate present in tonsillar crypts is pathologic. When the normal pillar contraction fails to empty the tonsillar crypts one of two things must of necessity have happened to the tonsil. Either there has been a stricture of the crypt with resultant retention, or there has been abscess formation and destruction of tissue with resultant cavitation. In either case infected material is retained to be absorbed at leisure by the blood and lymph channels. This retained material can surely be demonstrated and easily evacuated from the retention pockets and crypts of the tonsils by rather firm compression of the anterior pillar with a wooden tongue blade. The same maneuver as described before under rotation, only more force should be used. Pressure should be applied both superiorly and inferiorly, and it is interesting here to note that the common site for the appearance of tonsillar exudate is just at the edge of the anterior pillar superiorly. (Fig. I). This explains why quinsy is such a common complication of tonsillar infection.

There are three distinct types of tonsillar exudate: First, the whitish yellow fluid; second, the white cheesy material; third, the yellow waxy material. These exudates are pathonomonic of different periods of tonsillar disease. The liquid exudate is particularly associated with acute disease and is found during the acute stage of the infection only. As the infection progresses and ages the exudate thickens and the white cheesy material is found in the crypts. If this latter material is permitted to remain within the tonsil for a period of months it is compressed and hardened and the yellow waxy variety is formed. Anyone who has patience to follow a number of tonsillar infections over a long period of time can



FIGRE III. Dissection showing the Palato-Glossus Muscle of the Anterior Pillar as well as the Palato-pharyngeous Muscle of the Posterior Pillar.

This dissection was copied from TONSIL SURGERY by Robert H. Fowler, E. A. Davis Co., 1930.

verify this observation. Microscopically this exudate does not present a constant finding. The liquid variety shows all variations from frank pus with bacteria to bacteria with no pus. The cheesy material presents a homogenous matrix containing lymphatic and pus cells together with broken down debris, and large mononuclear cells. This type of exudate generally swarms with bacteria. The yellow waxy material is generally poor in cellular elements but does contain bacteria. To anyone who might doubt the coagulation of the liquid to the white cheesy material, could I remind them of the same phenomenon occurring occasionally in the ear canal adjacent to an acutely inflammed ear drum without there being any opening in the drum.

In reply to the critics who maintain that this exudate is nothing more than food debris caught in the crypts, I can say that it is only rarely that by staining methods the presence of food in this exudate has been demonstrated.

Laboratory workers[5] from examination and culture of the crypt contents have failed to lend material aid to the clinician in the evaluation of tonsils. They have, however, conclusively demonstrated that small contracted, innocent-looking tonsils as a rule contain more bacteria per gram and generally more virulent in type than the larger spongier tonsils. These small contracted tonsils can with compresison of the anterior pillar be made to reveal their infected material very easily and thus substantiate the findings of the laboratory worker.

That the contents of the crypt really tell the story of the tonsil has been beautifully illustrated at the Akron Children's Hospital this last year. We had repeated epidemics of diphtheria in the orthopedic wards and despite the usual prophylactic measures, continued to have new cases and it was only after the tonsils were compressed by the method here described and the crypt contents cultured that we were able to find three diphtheria carriers among the patients, who had been missed by the ordinary tonsil examinations and culture. As soon as these foci were eradicated, diphtheria ceased to exist in our hospital.

The pediatrician who has the opportunity to follow his patients over a period of years, viewing the tonsils at different stages, surely cannot help having a more rational, sound and complete opinion as to whether tonsils should be removed than a throat specialist who takes a one minute look. We should attack the problem of tonsil evaluation seriously and only after proper examination and consideration advise surgery. Compression of the tonsils is a simple procedure and the information obtained therefrom is enormous providing it is interpreted properly. I feel that the following conclusions are justified:

1. Normal tonsil crypts are free from macroscopic exudate.

2. The muscles of the pillars massage the tonsil and empty the crypts.

3. Only tonsillar disease causes the retention of exudate in the crypts and this retention and exudation can be demonstrated by compression and eversion of the tonsils.

4. A thorough history and a complete general and local physicial examination are essential for the proper evaluation of tonsils.

5. Diphtheria carriers can be demonstrated more easily by tonsillar compression with examination and culture of the expressed crypt contents.

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534 SECOND NATIONAL BANK BLDG.

DISCUSSION

BERMAN S. DUNHAM, M.D., Toledo: We have just listened to a paper of great practical value. If the maneuver of exposing the cryptic contents, as described by Dr. Kramer, is employed routinely in every questionable instance, much of the delay and guesswork in tonsillar diagnosis may be eliminated.

Personally, I do not subscribe to the opinion of some that tonsils should be removed simply because they are large, unless there is some accompanying difficulty, such as obstruction to swallowing or breathing, possibly in association with adenoids. Neither do I feel that history alone of frequent colds is in itself a sufficient reason for tonsillectomy. However, this should be done if upper respiratory infections recur repeatedly in spite of all possible medicinal, dietary and hygienic measures. Very important in this connection is the administration of vitamin A, the anti-infective vitamin, present in greatest concentration in the old-fashioned or regular cod liver oil. Egg yolk and fresh milk are important. Also, irradiation from the ultra-violet lamps, as a substitute for direct sunshine, is of value.

The demonstration of cryptic exudate is definite evidence of hopelessly diseased tonsils, however, and is a sufficient indication to warrant their removal at the earliest favorable opportunity.

It seems to me that tonsillectomy is a potentially serious operation, in view of the occasional accident in connection with the anesthesia or from some resultant post-operative complication. In order to avoid these it is important that the patient be examined and prepared beforehand. Any carious teeth should be corrected. Proper consideration should be given to the condition of the heart, lungs and kidneys as well as to the possible presence of an enlarged thymus. One should await the recession of any acute inflammation of the tonsils themselves and, if possible, a favorable season of the year.

High Spots of Program and Entertainment Features of Eighty-Sixth Annual Meeting, May 3 and 4, Dayton, Ohio

MONDAY, MAY 2

Medical and surgical clinics at various Dayton hospitals by members of the Montgomery County Medical Society.

Annual tournament of the Ohio State Medical Golfers' Association.

TUESDAY, MAY 3

Opening session of Annual Meeting and first meeting of the House of Delegates, 9:30 a. m., Junior Ballroom, Dayton-Biltmore Hotel.

Organization Luncheon for presidents, secretaries, treasurers, legislative and medical defense committeemen of the component county societies and academies of medicine, and the state officers and district councilors, 12 o'clock noon, Hotel Gibbons.

First sessions of the scientific sections, 2 p. m. Dayton-Biltmore and Miami hotels.

Annual banquet, 6:30 p. m., Dayton-Biltmore Hotel, to be followed by annual addresses of the president-elect, Dr. H. M. Platter, Columbus, and the retiring president, Dr. D. C. Houser, Urbana; an address by John B. Kennedy, popular broadcaster on "Collier's Hour", and an informal reception and dancing.

WEDNESDAY, MAY 4

Second, and final, sessions of the scientific sections, 9 a. m., Dayton-Biltmore and Miami Hotels.

General scientific session, the program for which will be presented by the College of Medicine, University of Cincinnati; College of Medicine, Ohio State University, and School of Medicine, Western Reserve University; 1 p. m., main ballroom, Dayton-Biltmore Hotel.

Final session of the House of Delegates, 3:30 p. m., Junior Ballroom, Dayton-Biltmore Hotel.

* * * * *

Registration headquarters, near entrance to the Exhibit Hall immediately to the south of the main lobby on the main floor of the Dayton-Biltmore Hotel, the headquarters hotel.

Scientific Exhibit, west side and southwest corner of the spacious hall immediately to the south of the main lobby on the main floor of the Dayton-Biltmore Hotel where the commercial exhibits also will be displayed.

Railroad ticket validation bureau, near Registration Headquarters, where "certificates" for reduced fares may be presented for endorsement and validation.

Annual Banquet Speaker



John B. Kennedy

One of the features of the annual banquet of the Ohio State Medical Association to be held at the Dayton-Biltmore Hotel on the evening of May 3, the first day of the 86th annual meeting of the State Association at Dayton, will be an address by John B. Kennedy, associate editor of Collier's and popular speaker on "Collier's Hour" over radio station WJZ.

Mr. Kennedy's address on "Civics for Civilized Men" will follow the annual addresses of Dr. D. C. Houser, Urbana, the retiring president, and Dr. H. M. Platter, Columbus, the incoming president of the State Association.

A record of having interviewed hundreds of celebrities, ranging from star athletes and theatrical notables to international scientists and statesmen, is held by Mr. Kennedy during his long experience in newspaper and magazine work. His journalistic career has taken him into most of the countries of Europe and in practically all of the metropolitan areas of America, giving him a wealth of information on economic, social and political questions which he will discuss in his address. During the World War, Mr. Kennedy was decorated for his war work by the governments of France and Belgium. For a time he was associated with Herbert Hoover, then director of the American Relief Administration. For the past six years Mr. Kennedy has appeared on the radio, specializing in short talks in the "Collier's Hour". He is director and master of ceremonies of the Collier's broadcast.

The Entertainment Committee of the Montgomery County Medical Society, headed by Dr. Charles H. Tate, Dayton, has charge of the sale of tickets for the banquet and is arranging to have them on sale at convenient locations where they may be purchased in advance of the time for the banquet.

Don't Forget To Get a Reduced Railroad Fare "Certificate"

Every member of the State Association contemplating traveling to Dayton by train for the annual meeting, May 3 and 4, is again urged to take advantage of the special reduced fare "certificate" plan arranged for with the Central Passenger Association when purchasing a ticket.

As pointed out on Page 291 of the April issue of *The Journal* in an article explaining in detail how the plan operates and how each member may secure the reduced rate, a minimum of 100 persons must participate in the "certificate" plan to make it operable. Providing at least 100 obtain "certificates", all certificate holders will be able to make the trip to Dayton and return at a cost three-fourths of the regular round-trip rate.

Tickets for the going journey (to Dayton) will be purchased at the regular one-way tariff fare, each person obtaining a "certificate" when purchasing his ticket. In case 100 or more obtain "certificates", each holder will then be able to obtain a ticket for the return journey (from Dayton) at one-half the regular one-way tariff fare. All "certificates" must be endorsed and validated.

Arrangements have been made to have a special agent representing the railroads located near the Registration Headquarters for validation of the "certificates". Members are urged to turn over to this agent their "certificates" as soon as they have registered for the meeting. As soon as the minimum number has been turned in, the "certificates" will be endorsed and validated, and returned to the holders upon request.

Special Entertainment for Visiting Ladies Planned

Special entertainment for the wives and daughters of members of the State Association who attend the Dayton meeting has been arranged by the Montgomery County Medical Society.

One of the features of the entertainment for the visiting ladies will be a luncheon on Tuesday noon, May 3, at the Country Club and a visit to some of the private gardens of Dayton following the luncheon. Automobiles to convey the lady guests to the club will leave the Dayton-Biltmore Hotel at 12:00 noon.

The President's Page

A Personal Communication to the Membership from

D. C. Houser, M.D., Urbana, Ohio

On May 3 and 4, medical organization in Ohio will conclude a successful year of activity and prepare for another twelve months of organized effort for the promotion of the science and art of medicine and the protection of public health in our great commonwealth.

I refer specifically to the Eighty-Sixth Annual Meeting of the State Association which will be held on the above dates at Dayton.

It is needless for me to comment at length on the preparations which have been made and the program which has been arranged for the Dayton gathering. The complete official program for the forthcoming meeting was published in the April issue of *The Journal*. It speaks for itself. However, I do feel that it is my duty to emphasize to the members of the State Association the importance of this occasion; to express again the opinion that the program formulated for the Dayton meeting promises to be one of the best ever arranged for an annual meeting of the State Association, and to voice the hope that the medical profession of Ohio will not miss this splendid opportunity to increase their knowledge on medical matters and to give their wholehearted and united support to the task of formulating plans and activities for carrying out the purposes for which medical organization was founded.

As has been said on a previous occasion, the Council program committee, the section officers and the various committees on arrangements, both state and local, have spared no time and effort in an endeavor to make the 1932 annual meeting one of outstanding interest and value for the membership generally. Those who attend will be abundantly repaid for doing so.

It seems to me that there never has been a time when the need for serious, thoughtful and thorough deliberation on the vital questions which confront the medical profession has been greater. There are many acute social and economic problems which vitally affect us that deserve our deep consideration and study.

Many physicians as individuals are devoting serious thought to these complex and confusing questions. Practically all the county societies and academies of medicine, I know, are spending considerable time and effort analyzing them and endeavoring to solve them locally. However, there is no denying the fact that many of these acute questions are not simply matters of local concern; are not questions which affect one or several groups of physicians. Many are questions not only of state-wide interest, but also of nation-wide importance. They must be studied, analyzed and solved, if possible, by medical organization as a whole.

That is one reason why the medical profession of Ohio must continue, federated and united into one compact organization. That is one reason why once a year the entire medical profession of the state assembles at one time and place. That is one reason why the Annual Meeting is of extreme importance to every physician in the state. In brief, it offers an opportunity for learning about the problems of our colleagues; for studying the questions which are confronting the entire profession; for reaping the benefits and advantages of the counsel and advice of the keenest minds in the profession, and for obtaining the united medical viewpoint on matters which affect us individually and collectively.

No physician in the state can afford to pass up this opportunity. I especially urge the secretaries of the various component county societies to impress upon physicians who are delinquent with their annual dues the importance of good standing in medical organization, one of the chief benefits of which, in my opinion, is to be privileged to gather once a year with their colleagues from all parts of the state and deliberate on mutual problems, economic as well as scientific.

Furthermore, I cannot recommend too emphatically that the entire membership read from cover to cover this issue of *The Journal*, the large part of which will be devoted to the annual reports of the standing and special committees of the State Association. Many of the questions which I have referred to in a general way and briefly, will be analyzed in those reports.

Annual Report of the Committee on Public Policy

JOHN B. ALCORN, Chairman, (1933) Columbus
C. W. STONE, (1932) Cleveland
J. H. J. UPHAM, (1934) Columbus
D. C. HOUSER, (ex-officio) Urbana
H. M. PLATTER, (ex-officio) Columbus
DON K. MARTIN, Secretary Columbus

An analysis of the numerous problems concerning public health and medical practice which have been considered, studied and acted upon by the Committee on Public Policy during the past twelve months is ample evidence that the medical profession at the present time is facing one of the most, if not the most, crucial period in its history. The entire world is passing through an era of unrest. Demands for a change in the social, economic and political order are becoming more insistent.

In such times of unrest, radicals, theorists, reformers, uplifters flourish. They propagandize for a new social and political structure. Artificial panaceas are advocated to correct social and economic imbalances, which would add new governmental functions, create greater centralization, more bureaus and departments, and new services to supersede local responsibility, individual initiative and enterprise.

Governmental and legislative developments at Washington have been closely followed by this committee, not alone for the direct effect they may have on the practice of medicine and the protection of public health, in a national way, but for the examples set by Congress for proposals and legislation which inevitably may be expected in Ohio and the other states.

For example, in the present session of Congress there are various "social service and welfare" bills which seek to appropriate the staggering sum of over twenty-five billions of dollars, much of it for subsidies, doles, or for state distribution for various activities in the field of "health and welfare". This amount is in addition to the regular appropriation bills for federal government maintenance.

When one considers the situation in Great Britain with its annual outlay of 400,000,000 pounds for "Public Social Service" for England, Wales and Scotland alone, with a population of 44,000,000, the possibilities in this country, for similar paternalistic activities, are apparent.

The many proposals and changes already adopted into the social structure of America for "socialization", both in and outside of government itself, especially in the field of welfare, social service and health, have changed to an amazing extent the relationship for a considerable portion of the medical profession to their clientele. The same factors which have been responsible for a change in the relationship between physicians and the public, also have brought about a change in the relationship between individuals and groups within the medical profession. Confusing and complex problems of professional relations and ethics, some with entirely new angles, have sprung up, none of them being easily interpreted or analyzed because of the divergent viewpoint within the ranks of the profession.

As this would indicate, the Committee on Public Policy has been called upon to consider an ever-increasing number of perplexing questions, ranging from those of governmental functions and legislation, to acute problems of ethics and professional conduct.

In all its deliberations, this committee has endeavored to represent the sound, concerted, conservative medical viewpoint. It has tried to gauge its attitude and action by what it believed to be of the greatest public benefit. At all times it has sought to obtain the best united thought of the profession, and expressions of policy have been voiced only after thorough study and careful consideration. The committee has sincerely endeavored to think clearly and correctly, and to take fearless action when the occasion demanded.

LEGISLATION AND GOVERNMENT

Questions arising from state and federal governmental administration and legislation are daily becoming more acute. Many of these have a direct bearing on matters of public health and medical practice, and most of them to some degree affect each physician individually. The times demand continuous alertness and often vigorous activity on the part of organized medicine.

The medical profession must not only make every effort to guide those multifarious movements of a social-welfare-health nature, on which it is most fully informed, concerning what is best in the public interest; but also it must be prepared, in case the tidal wave of change sweeps away present landmarks, to reconstruct and preserve those principles and relationships which are necessary for public health and scientific medicine.

The antiquated theory that medical organization need not greatly concern itself about governmental and legislative questions, unless they pertain *directly* to public health, scientific medicine and medical practice, must be discarded. Present-day developments clearly show that practically all questions, social, economic and political in nature, have some effect, large or small, on public health; tend to modify to some extent medical practice; and affect in many ways the social and economic status of the individual physician. It is the duty and responsibility of every member of medical organization to keep himself accurately informed on the trends in government and legislation, and to take an active, personal interest in moulding public opinion in accordance with the fundamen-

tally sound, concerted medical viewpoint on matters affecting public health, medical practice, scientific medicine, and the social-economic status of physicians.

The need for strong, united and alert organized activity on the part of medical organization was demonstrated during the 1931 session of the Ohio General Assembly, when, as pointed out in the last annual report of this committee, approximately 200 bills and resolutions, which had some bearing on questions of interest to the medical profession, were introduced. The work of the committee in dealing with these questions, as summarized in the 1931 report of the committee (May, 1931, issue of *The Journal*), approved by the House of Delegates at the Toledo annual meeting, emphasized the necessity for continued aggressiveness and alertness on the part of the State Association in the governmental-legislative field.

Further evidence of this need is found in a recent survey of state legislation, since January 1, 1931, by Dr. William C. Woodward, director of the Bureau of Legal Medicine and Legislation of the American Medical Association, which shows that more than 3,000 bills of direct medical interest were considered by the legislatures of the various states last year in addition to the hundreds in the federal Congress.

There is little at present to indicate that the craze for more laws, more regulations, more bureaus, more centralization, and the further expansion of governmental activities into the domain of individual liberty will be checked in the immediate future. On the contrary, recent investigations by this committee and the study of data in the hands of the committee, including tentative drafts of proposals to be presented at the next session of the Ohio Legislature, lead the committee to believe that the next session of the General Assembly will witness the introduction of a record-breaking number of radical, dangerous, special-privilege and socialistic measures.

It is highly probable that at the 1933 session of the Legislature there will be a veritable flood of schemes advocating social insurance of many varieties, including compulsory state health insurance, various kinds of pensions, state-aid programs, and other such projects, which usually crop out in the wake of hard times and social unrest. Cultists, foes of scientific medicine, and others who have sought previously to destroy the safeguards to public health and to break down the high standards surrounding medical practice will promptly align themselves with the radicals and agitators in an effort to capitalize on the unsettled situation generally and gain support for their destructive proposals.

As leading citizens, physicians should take an active interest in public affairs. Thought should be given to candidates for public office who are to be chosen at the coming primaries on May 10, especially as to the qualifications and attitude of the legislative candidates.

Medical organization must be prepared to play an aggressive role during the period of readjustment which will eventually arrive. To lay the groundwork for some of the activities which the State Association must pursue, the Committee on Public Policy has during the past year held conferences with representatives of allied organizations and of other state-wide groups interested in health-medical-welfare problems. New contacts have been formed and old ones strengthened. It is respectfully suggested to the component county medical societies and academies of medicine of the State Association, that they follow the same procedure in their respective communities, so that medical organization and its allies may present, when the necessity arrives, a united and vigorous opposition to legislation judged detrimental to public health and a menace to good medical practice and scientific medicine.

FEDERAL QUESTIONS

The present session of the Seventy-Second Congress has been termed by many political observers the most important session ever held by the nation's law-making body, because of the grave questions growing out of the unsettled world conditions. As anticipated, Congress has had under consideration an unprecedented number of unsound, radical and destructive measures, ranging from fantastic social insurance and subsidy schemes to those providing for more bureaucratic machinery and new raids on the nation's treasury.

Careful study has been devoted to problems arising from the administration of the World War Veterans' Act and to legislative proposals in connection with the government's medical and hospitalization program for ex-service men.

The question of veterans' relief has become one of the outstanding, vital problems confronting the nation, not only because of the enormous monetary outlay required to administer it under existing methods, but also because of the fundamental principles involved. The question is of significant importance to the medical profession because of its numerous complicated medical angles.

From the time of the passage of initial legislation providing benefits for veterans of the World War, the announced policy of the medical profession of Ohio has been that everything possible should be done, including medical, surgical and hospital services, for all veterans whose disabilities arose from military service, and that such benefits should be available to those veterans with non-service connected disabilities unable to provide them for themselves. This sentiment still has the wholehearted support and backing of the medical profession.

However, the medical profession, through medical organization, has from time to time objected

to the policy of providing medical and hospital benefits to any and all former service men, with non-service connected disabilities who are amply able to pay for such services for themselves, and to the elaborate and extensive hospital building program of the government to provide institutional care for all classes of veterans, and possibly their families and dependents.

The present policy, to which the nation has been committed by statutory enactments, the medical profession believes fundamentally unsound and contrary to the principles of good government.

Specifically, the medical profession believes that the policy of the government in providing medical and hospital benefits for veterans suffering from disabilities incurred in civilian life, who are amply able to provide medical services for themselves, and in erecting hospitals to care for such cases is nothing less than an elaborate system of state medicine. This system, it has been pointed out, eliminates the free choice of medical service for the individual (providing the individual is unwilling to pay for such service for himself); places the government in direct competition with the practicing physician and with privately-owned and operated hospitals; provides the country with many government-owned institutions for which the need will eventually disappear; and paves the way for extension of medical and hospital service at government expense in these former veterans' hospitals to federal employes, the families of veterans, and even the general public.

The committee has followed with interest several recent conferences between physicians and officials of The American Legion for the purpose of discussing the various angles of the present government program for providing medical and hospital services for ex-service men, and including the proposal for an insurance plan of benefits for all World War veterans as suggested in the Shoulders' Resolution adopted by the House of Delegates of the American Medical Association at the last A. M. A. meeting at Philadelphia and analyzed in the August, 1931, issue of *The Ohio State Medical Journal*, pages 643-646.

Despite arguments for the Shoulders' plan that it would decentralize the present elaborate medical and hospital program of the government; permit World War veterans to obtain medical and hospital care in their own communities from local physicians and local hospitals, and curtail the costly hospital building program to which the government had been committed, there has developed a sentiment among many who have given thorough consideration to the question, that the Shoulders' plan is not the final solution to the problem and that the Shoulders' plan itself would establish a system of state medicine for all ex-service men, even those suffering from non service-connected disabilities who are able to provide such care for themselves.

The opposition developing to the Shoulders' Resolution is confirmatory of the official policy adopted some years ago by the House of Delegates of our State Association and adhered to by this committee approving government benefits, including medical and hospital services, to all ex-service men whose disability arose from military service, and to those ex-service men with non service-connected disability who are unable financially to provide medical and hospital attendants for themselves.

Other federal legislative proposals have been considered by the committee, including proposals for reestablishing federal subsidies to the states for work in infant and maternal hygiene, in effect, an effort to revive and perpetuate the principles of the old Sheppard-Towner Act; amendments to the National Prohibition Act which would modify and change sections of that act governing the dispensing and prescribing of medicinal liquor; measures sponsored by anti-vivisectionists which would prohibit the use of dogs for purposes of research, and various other proposals having a health-medical-welfare angle.

The committee has either acted directly, supporting or opposing such measures in communications to members of the Ohio Congressional delegation, or assisted the Bureau of Legal Medicine and Legislation of the American Medical Association, basing its action at all times on definite principles and policies previously laid down by the House of Delegates of the State Association.

POOR LAWS AND FEE SCHEDULES

During the past year, the committee has studied questions arising from the administration of the "poor laws", especially problems relative to the payment of physicians for services rendered to indigent patients.

The attention of the committee was called to several instances in different sections of the state where physicians have encountered difficulty in obtaining payment for services arising from the administration of the laws dealing with poor relief. These were studied and analyzed in detail in the March, 1932, issue of *The Journal*, pages 203 to 206.

This question is especially pertinent at the present time because of the increase in the number of persons depending on public funds for food, clothing, shelter, medical care and other essentials to life and health.

This committee feels that the question is largely one of local administration and local determination. A satisfactory solution should be worked out jointly by a committee from each county medical society or academy of medicine and the local public officials. A mutual and proper understanding of the responsibilities of public officials, as well as the medical profession, to the indigent sick should be attained, as well as an understanding of the proper spirit of cooperation that should exist between these two groups. Numerous in-

stances could be cited where proper understanding and cooperation have been developed by effective and concerted effort on the part of the county medical society, and where public officials have been convinced of the desirability of providing the dependents of the county with the proper type of medical service for which fair compensation is paid.

The possibility of attempting to have inserted in the present statutes on poor relief a definite medical fee schedule, or reference to the fee schedule governing Workmen's Compensation cases has been suggested. The committee is of the opinion that the established policy of the State Association, discouraging the adoption of standard fee schedules by county medical societies, is a proper and wise policy and should be adhered to. A number of embarrassing and involved problems have been created in the past through the adoption of standardized fee schedules by some county medical societies. Furthermore, the committee believes that any effort to standardize fees for medical services to indigents by legal enactment should be avoided, since such procedure might lead to misunderstanding on the part of the public that such schedule constituted the "legal fees" even in private practice and would otherwise lead to embarrassing litigation.

In this connection, attention is called to the provision in the suggested by-laws of a model constitution for component county medical societies, drafted by the Committee on Constitutional Conformity of the State Association, which reads that "agreements and schedules of fees shall not be made by this society (county medical society), but at least one meeting during each year shall be set apart for a discussion of the business affairs of the profession of the county with the view of adopting the best methods for the guidance of all". This is a wise and safe policy for each county medical society to pursue. However, questions of medical economics, including that of fees for various types of service, may properly be discussed at meetings of county medical societies.

PROFESSIONAL RELATIONS AND ETHICS

An unfortunate and dangerous development in the past few years has been the movement to commercialize medical practice—to virtually eliminate it from the field of professional service and place it in the same category with distinctly industrial and commercial vocations.

As a result of this trend, which has affected no small portion of the medical profession, problems of professional relations and ethics have increased, calling for re-interpretation and reanalysis of factors which have long governed the relationship existing among physicians, and between physicians and the public.

Questions involving exploitation of patients; doubtful and questionable publicity and advertising ventures; fee splitting; excessive specilization; misleading representation of skill and competence, and other evils growing out of a desire on the part of some individuals, within and outside the medical profession, to classify private medical practice as a commodity and not a private professional service, have created confusing and perplexing situations.

In the words of one writer, this development has resulted in unethical tactics, unwise judgment, bad taste and unscientific medicine, on the part of physicians who think the long-established and fundamentally sound principles of ethics and professional conduct of medicine are moss-backed and obsolete, and are engaging in practices having the ear-marks of quackery.

There is no valid reason why the fundamental provisons of the code of ethics in medicine should be revised at this time. As a special committee of the Council quite properly pointed out, following consideration of the various angles of the general problem of professional advertising and publicity: "There is as much protection in the professional code of ethics as there ever was. Professional propriety may be determined in each instance on the basis of the greatest public good, medical ethics, scientific judgment and good taste".

It is inevitable that certain customs and rules amplifying the fundamental principles of the code of ethics should be modified from time and time to meet changing social conditions. This has been done on many occasions and will no doubt be done frequently in the future. However, the old ideals, morals and principles of fundamental human relationship should always apply in the practice of medicine. In the words of one leader in medical thought: "It is reasonable to believe that the tottering of a few during this time of stress will not become the example that will lead the rest of the profession to follow the black sheep blindly over the precipice".

New angles in the question of professional relations are constantly arising because of the rapid increase in the number of persons engaged in health and medical activities, in the number of individuals belonging to professions accessory to medicine itself, and in the number of nondescript healers, practicing some limited branch of medicine or exploiting some ism or cult.

Just what the attitude of the physician should be toward many of these individuals and groups is not always clear and requires careful study and interpretation.

This committee believes that the answer to some of these problems is found in the minutes of the Council meeting of July 12, 1931 (page 651, August, 1931, issue of *The Journal*) when a specific question of professional relations was discussed.

The sentiment of the various members of the Council, in which your committee concurs, was that it is unprofessional for any physician to call

into consultation unqualified practitioners, and that it also is unprofessional for physicians to consult with practitioners inadequately trained in the medical sciences "who are unfit or unqualified because deficient either in moral character or education" (Chapter 2, Section 7, Code of Ethics), or to jointly treat cases with such persons.

It was the opinion of the Council also that in cases of emergency, physicians having a humanitarian duty, might properly render service to patients even though called by unqualified practitioners, provided, however, that physicians should not continue to handle a case jointly with such persons following such emergency.

Furthermore, it was emphasized in this connection that in local matters of professional relationship and ethics, the county medical society has the entire original jurisdiction and that the responsibility for initiating disciplinary actions rests with the county medical society.

Hospitals quite often are confronted with similar questions arising from the insistence of unqualified practitioners that they be given equal rights with members of the medical profession in hospital privileges. While it is clearly recognized that the officials of any hospital have the power to conduct the hospital in any way they deem wise, as long as all laws are observed, the fact should not be overlooked that it is the moral duty and responsibility of every hospital management to provide the sick and injured with the best possible care, and also to refuse hospital privileges to those who are unqualified and incompetent.

Also, it should be borne in mind that a hospital to qualify for the endorsement of the Council on Medical Education and Hospitals of the American Medical Association and seeking admission to the register of that body must first of all comply with the following requirement:

"A staff made up of one or more properly qualified physicians who shall be graduates of reputable medical schools; and all physicians treating patients in the hospital must be so qualified."

Obviously any hospital that is unable to meet this requirement can give little assurance that its clientele will be properly safeguarded or receive the type of service to which the patients are entitled.

MISCELLANEOUS ACTIVITIES

It is believed that during the past year the contact between medical organization in Ohio and other groups, agencies and organizations interested in health-medical-welfare problems has been extended and strengthened.

The Committee on Public Policy has considered many questions of mutual interest to the medical profession and other professional and non-professional groups. The cooperation and assistance of medical organization has been offered in activities not in conflict with principles and policies laid down in past years by the House of Delegates of the State Association. A sincere effort has been made to clearly state the correct medical viewpoint and thought of the medical profession on questions considered jointly with other groups and to insist that the fundamentally sound and united sentiment of the medical profession should predominate in matters of public health and medical practice.

Some of the more important activities of the committee in this connection are briefly as follows:

Frequent conferences, and development of a high degree of cooperation with the Director and other officials of the State Department of Health; strengthened relationship with local health commissioners, many of whom are not only active members of their county societies but who are serving or have served as officers and committeemen or as delegates to the State Association.

Contact and cooperation with the Ohio State Pharmaceutical Association was continued and strengthened along the lines described in detail in the 1930 report of the committee when the committee pledged its assistance to a joint effort on the part of the organized medical profession and the organized pharmacy profession to stimulate cooperation among members of both professions and to bring about a better understanding on the part of each of the common and individual problems of both professions.

At the request of the general secretary of the Ohio State Nurses' Association the committee considered the draft of a letter to the physicians of Ohio from the Board of Trustees of the nurses' association in which there was outlined a program of cooperation between physicians and nurses, and a request made that physicians give precedence to Ohio registered nurses over nurses not registered in Ohio. The letter, revised slightly to conform with suggestions made by the committee, was subsequently approved by the Council, indicating that the Council agreed with the Committee on Public Policy that friendly, cordial and cooperative relations should exist at all times between these two professions.

A number of important questions arising from enforcement of the new state law requiring chauffeurs to undergo a physical examination annually as a part of the procedure in applying for a license from the State Bureau of Motor Vehicles have been considered by the Policy Committee.

Friendly and cooperative contact has been established with that Bureau, and as a result of suggestions and recommendations made by the Policy Committee, the procedure relative to physical examination of chauffeurs has been simplified. A practical and satisfactory method for obtaining information and data from private physicians selected by chauffeurs to make the physical examinations has been set up.

Furthermore, with the cooperation of the committee, the Bureau has established definite policies regarding this phase of the licensing law, which, it is believed, will minimize, if not eliminate, a recurrence of misunderstandings between the Bureau and physicians making the required physical examinations. Chief among the policies formulated by the Bureau are: Free choice of the physician, to make the physical examinations of applicants for license, providing the physician is competent and qualified to make the examination, and the elimination of as much red tape as possible in obtaining the data required.

Cooperation was tendered the committee appointed by Governor White to arrange the Ohio

follow-up to the White House Conference on Child Health and Protection, held in Columbus last January. The suggestions and advice of the committee were sought by those interested in arranging the health program given at the conference.

At the direction of the Council, the committee studied a proposal emanating from the Committee on Medico-legal Problems of the American Medical Association and endorsed by the Board of Trustees of the A. M. A., urging the establishment of a criminologic institute in each state not already provided with such an agency for the detection and punishment of crime. Considerable correspondence from the A. M. A. and other sources on this subject was reviewed.

Your committee believes the proposal has considerable merit and is in the interest of good government. The detection and punishment of crime is a major problem at the present time and experience has shown that science can do much to aid in accomplishing those ends. For this reason, every community should be provided with or have access to some agency equipped to give complete and accurate scientific data and advice essential for the prompt detection and punishment of crime. Because of the medical angles of the question, the medical profession should be especially interested in it. Further conferences on this question with various state officials and other groups interested in it have been planned. Meanwhile, your committee is cooperating with the A. M. A. in obtaining additional data that might be of value in consideration of the proposal and in stimulating interest in it.

Following careful thought and deliberation, the Committee, with the consent of the Council, has recommended to the Council on Medical Education and Hospitals of the American Medical Association that an authoritative inspection of osteopathic schools be made at any early date in order that additional authentic information regarding the educational status of such schools may be available.

It has been suggested by your committee that in case difficulty is encountered in obtaining the sympathetic cooperation, and permission from the officials of osteopathic schools for an inspection by the Council on Medical Education and Hospitals, an effort be made to have some nationally recognized educational group not directly affiliated with medical organization itself undertake this task, for example, the Carnegie Corporation of America or a similar foundation.

Occasionally, there has been need to reemphasize the sound policy of medical organization relative to procedure in immunization, vaccination and similar official public health activities. This policy is, in effect, that public health officials should confine their activities in this phase of preventive medicine to services to those unable to pay, and to the education of the public, unless the physicians of the various communities as a group consent to or request public health officials to render this service to others in the community. In general, mutual cooperation and understanding between health officials and the medical profession on definite policies and procedure have resulted in efficient programs of public health activities in most cities and counties of the state.

In conclusion, your committee wishes to reemphasize the need for and value of an active interest by every physician in the program and activities of medical organization. The questions referred to in this report demand the careful consideration of every physician, for these, as well as other important and vital problems, cannot be satisfactorily solved unless there is united, harmonious and vigorous organized activity on the part of physicians through their county medical societies and the State Association.

Annual Report of The Committee on Medical Economics

J. CRAIG BOWMAN, Chairman, (1933) Upper Sandusky
E. O. SMITH, (1932) Cincinnati
A. B. BROWER, (1934) Dayton
DON K. MARTIN, Secretary Columbus

The world today is full of perplexity. This nation, as well as others, is passing through a dangerous period. This is not all occasioned by unemployment, changes in social structure, collapse of markets, readjustment in industry and business, and redistribution of property. The real danger is that under the stress of abnormal conditions, we may be stampeded into unwise departures which will change the fundamental character of our government and in the end change the character of the people themselves.

Probably at no time in the history of civilization have there been so many cross-currents of thought, so many paradoxes, so many doubts, so much anxiety, so much confusion and such bewilderment, as now, due largely to the upheaval taking place in the economic and social order.

The social order is passing through a cycle of experimentation. Changes in long-established social and economic procedures have been rapid. The craze for a change, regardless of the consequences, has become pronounced. Pessimists have predicted that civilization itself is sweeping towards a cataclysmic downfall. Some economists are of the opinion that the present economic-social system will eventually make the grade back to its normalcy. Others argue that the world is in a period of transition from the old order of things to a new one about which little as yet is known.

Little wonder that the public is bewildered and finds itself asking the questions: Shall we turn to the right or to the left? Shall we make the effort to climb the steep, hard way, or take the temporary, easiest way? Or, shall we march straight ahead?

As one writer has expressed it:

"The great issue now is whether the American people will continue to work out their national destiny with intelligent patience, through evolution, or whether they will yield to the extremists

who will take nothing less than an immediate and complete solution of all economic problems."

The gravest mistake which has been made so far by many who have tried their hand at readjusting the mechanics of medical practice and medical service is that they have failed to take into consideration the fact that the questions of medical care, medical costs, and their related problems, are but parts of the whole economic picture.

The fundamental principles underlying the whole economic and social structure cannot be disregarded in studying medico-social problems any more than they can be ignored in the consideration of the problems which confront other professions, industry and business in general.

The practice of medicine is confronted with the two-fold responsibility of adjusting itself, first, to its own changing technics, and second, to the changing organization of society.

Readjustment of medical practice to give the public the benefits of new discoveries in scientific medicine; new methods of healing the sick and injured and protecting the public health, has become a gradual, constant and rational procedure.

The difficulties which frequently follow any modification of the relationship between the medical profession and the public are reflected in problems which have arisen as a result of the expansion of governmental functions in the field of medicine and health; the exploitation of socialized health and medical undertakings, and the increase in the number of unnecessary undertakings, and in the number of duplicated specialized movements.

In the face of strong possibilities for vital changes in the social order, which may compel modification in present methods of caring for the sick and in the distribution of the costs of sickness, the medical profession cannot assume an attitude of laissez-faire. It cannot be indifferent to what is taking place about it. It cannot, without risk of creating new animosity toward the profession, condemn, without thorough investigation, new programs and proposals. It cannot afford to expose itself to the accusation that it is not thinking logically and unselfishly. On the other hand, mere pressure of propaganda or pre-conceived plans should not cause the medical profession to acquiesce in a new and theoretical departure from time-proved principles.

ISSUES MUST BE FACED

In the words of Dr. Olin West, secretary of the American Medical Association:

"Leadership can hardly develop and be effective unless the intelligent units of the rank and file are properly informed and they will be informed only as they seek information and expend some effort of their own to get it."

New activities, or the extension of present programs, may be found necessary in the future to meet changing social and economic conditions. When that time arrives, the alertness and initiative of medical organization will be put to a still greater test. If these new activities and movements can be justified on the basis of a definite need and in the best interests of the public, and are fundamentally correct, scientifically and economically, they should receive approval and cooperation.

However, there is now no good reason why medical organization should compromise its present attitude toward border-line and questionable, unsound and impractical undertakings in the field of medicine and health. The principles which have been used in the past to test all such activities still are fundamental and sound, despite the clamor raised from many sides that they are worn out, obsolete and antiquated.

It seems to this committee that no better guide has so far been established for indexing medical and health activities and for determining the attitude which medical organization should take towards them, than the summary published in the report of this committee two years ago of pronouncement of policy made at various times by the House of Delegates of the State Association, to-wit:

"Any plan or system which affects the medical profession detrimentally will inevitably be detrimental to the public as well. Any plan, system, or activity which tends to destroy or lessen scientific research, individual initiative and ambition, adequate remuneration for effort and ability, personal responsibility; which would lower the standards of medical education or inculcate unsound ideas in the public mind toward scientific medicine, are wrong, unwise, impractical, and will inevitably be doubly costly to the public."

Thus, in brief, are some of the responsibilities which medical organization faces during the coming year and years. Whether medical organization will be able to cause more than a ripple on the vast flood of change now threatening to submerge the social order is, of course, problematical. Medical organization may be forced eventually to meet what some are now pointing to as the inevitable—complete socialization of medical service.

But even if the worst comes, and the medical profession cannot stem the tide and direct the current, it must be united in its efforts. On the principle that society needs and always will need competent and qualified medical thought and personal professional service, we must be prepared to reconstruct, preserve and perpetuate our scientific independence and insure our economic security. Whatever happens, we must maintain strength in medical organization. No qualified, ethical physician can afford to isolate himself from his county society and State Medical Association.

LIABILITY FOR MEDICAL REPORTS

Following the detailed study of the relation of the Ohio Workmen's Compensation Law to the

practice of medicine made by the Committee on Medical Economics more than a year ago and summarized in the 1931 annual report of the committee, this committee during the past year has given additional consideration to this question.

Pursuant to instructions from the Council, the Committee on Medical Economics jointly with the Committee on Medical Defense, has investigated and studied questions concerning the liability of physicians for reports of diagnosis and physical findings made to third parties, with special consideration to such questions arising out of workmen's compensation cases.

There are several recent instances in Ohio where physicians have been sued for malicious libel and slander for having submitted to the State Industrial Commission medical findings adverse to claimants. There also are several cases on record where physicians have been sued for reporting to employers the physical condition of employes sent to them for special examinations.

The seriousness of this question is obvious. Analyzing the question from a broad, general point of view, it seems to this committee that it is fair, logical and in accordance with good government that any physician, who is required by law to make medical findings and reports to a governmental agency, should be properly safeguarded in some manner in such cases against incurring civil liability to patients. Furthermore, it is to the advantage of governmental agencies which require such reports that physicians be encouraged and supported in making honest and accurate reports of diagnoses.

A series of conferences was held with officials of the Department of Industrial Relations and the State Industrial Commission on the question of protection for physicians handling workmen's compensation cases. As a result, steps have been taken by the Commission to safeguard physicians in the submission of medical information to the Commission.

There has been printed on the new workmen's compensation application forms, which are signed by the claimant and filled out for the most part by the attending physician, a statement authorizing the physician to make disclosures of diagnosis and treatment of the claimant who signs the application to the State Industrial Commission and others authorized to receive such information without incurring civil liability to the claimant.

The statement, now printed on all application forms, reads as follows:

"By signing this application, I expressly waive, on behalf of myself and of any person who shall have any interest in this claim, all provisions of law forbidding any physician or other person who has heretofore attended or examined me, or who may hereafter attend or examine me, from disclosing any knowledge or information which he thereby acquired."

PRIVILEGED COMMUNICATIONS

The committees on Medical Economics and Medical Defense also have assembled considerable data on the intricate question of privileged and confidential communications.

Study of this question reveals that a distinction may be drawn between "privileged communications" and "confidential communications".

Privileged communications may be considered a technical legal phrase relating to two classes of communications: (1) those between a patient and his physician which may not be lawfully disclosed in a court without the consent of the patient, express or implied; and, (2) certain communications referred to in the law of slander and libel.

As a general principle, it may be stated that all communications between a patient and his physician, no matter how they are made, are confidential communications. But, communications between a patient and his physician are not in the first intsance to be understood as privileged denunciations which they may become when the question arises in litigation.

The obligation of a physician to respect the confidence of his patient is a part of a physician's professional duty to his patient, no matter whether the relation of physician and patient is looked upon as one of contract or one arising out of the status of the parties independent of any contract. Whatever the attending physician learns concerning his patient, whether by inquiry or by examination, should, as a matter of principle, be kept secret. Disclosures without the consent of a patient (or in the case of a minor or a lunatic without the consent of the parents or guardian) is made at the physician's peril. Of course, many disclosures are not harmful and therefore not actionable, but in principle they are wrong.

However, this obligation to secrecy, growing out of the physician's contract or out of his relation, may be overcome by stronger obligations. The outstanding stronger obligations are those imposed by valid statutes, ordinances, and regulations requiring disclosures, as in the case of statutes, ordinances and regulations requiring the reporting of births, still-births, of the causes of still-births, of the causes of death, of contagious diseases, and where disclosure is lawfully required on the witness stand before a competent tribunal.

The second group of cases in which a physician may disclose otherwise confidential information is by no means so clear. Such disclosures, if they exist at all, come within the class of communications referred to previously as "privileged communications" in connection with the law of slander and libel. The nature of such communications is well shown by the statement in 17, Ruling Case Law, 341, Section 88:

"Publication is conditionally or qualifiedly privileged where circumstances exist, or are reasonably believed by the defendant to exist, which cast on him the duty of making a communication to a certain other person to whom he makes such communication in the performance of such duty, or where the person is so situated that it becomes right in the interests of society that he should tell third persons certain facts, which he in good faith proceeds to do. This general idea has been otherwise expressed as follows: A communication made in good faith on any subject matter in which the person communicating has an interest, or in reference to which he has a duty, is privileged if made to a person having a corresponding interest or duty, even though it contains matter which, without this privilege, would be actionable, and although the duty is not a legal one, but only a moral or social duty of imperfect obligation."

Thus, we find that privileged communication may have one meaning in the law of evidence and another meaning in the law of libel and slander. In the law of evidence a privileged communication is a communication between a physician and his patient concerning some matter confidential in its nature that is necessary to enable the physician to treat his patient, the admission of such communication in evidence in court without the consent to the patient, or someone authorized to act in his behalf, being forbidden by statute. A privileged communication, as the term is used in the law of slander and libel, is a communication that would be libelous or slanderous but for the fact that it is made under circumstances that give to the person who makes the communication the right to do so without incurring personal liability.

In general, all privileged communications may be said to be confidential, but the converse is not true. In fact, most confidential communications never acquire the status of privileged communications. For instance, it has been held by some courts that communications between a physician and a patient incident to the examination of the patient by the physician at the request of a third party to enable the physician to evaluate the nature and extent of the disability of the person examined, are not privileged. However, this does not mean that such communications are not confidential.

Owing to the seriousness of this question from the standpoint of the physician your committee recommends that every physician keep in mind at all times his ethical and legal obligations and responsibilities, and refuse to disclose to a third party confidential information unless protected by a written or implied valid waiver from the patient himself or persons legally entitled to act for him, or by statutory provision giving the physician the right to divulge such information without incurring personal liability.

WORKMEN'S COMPENSATION PROBLEMS

In its contact with members of the State Industrial Commission through conferences, correspondence, and the Headquarters Office of the State Association, the Committee on Medical Economics has endeavored to assist the Commission in working out improvements in the routine system used by the Commission in handling cases, especially in the matter of speeding up the payment of physicians' fees.

As a result of a number of changes which have been made in the procedure at the Commission's offices, some delay in the payment of compensation and medical fees, especially fees in "medical only" cases, has been eliminated. Additional changes in the departmental routine have been suggested and are now being considered by the Commission. It is believed that adoption of these modifications will further improve the routine system and assure physicians of greater promptness in receipt of medical fees.

The attention of the Commission has been called to instances where physicians, as well as claimants, have been unable to learn promptly the status of cases because of a delay at times on the part of the department in answering inquiries and correspondence. Steps to minimize such oversights have been taken by the Commission.

The danger which a physician faces when he makes a medical report adverse to a claimant has been re-emphasized to members of the Commission. Several new instances of physicians being threatened by disgruntled claimants have been cited. This committee has urged the Commission to take prompt steps to meet this situation, possibly by working out some plan whereby reports and communications of this nature from physicians would be held in confidence by the Commission and not filed with reports which are available for public inspection.

This committee wishes to re-emphasize the importance of active cooperation on the part of the medical profession with the State Industrial Commission. Some of the difficulties encountered by the Commission would probably be minimized, if not eliminated, should some physicians realize more keenly the responsibilities placed on them by the Commission; furnish the department with complete, legible and accurate reports and information, and adhere as closely as possible to the flat rate schedule of fees for medical and surgical services.

Records of the State Industrial Commission reveal a few instances where a physician has submitted a fee bill for services to patients who were never seen by him but where medical attention was rendered by a nurse or technician employed in the physician's office.

As a result of this misunderstanding on the part of some physicians, the Commission within the past year officially adopted the following resolution embodying the sentiments of the Commission on this question:

"No fees will be paid to a doctor for services rendered by an assistant who is not a registered

physician, unless the doctor is present and directly supervises the treatment."

In taking the foregoing action, the Commission, we believe, had in mind the principle that physicians are just as responsible for personal professional service in workmen's compensation cases as in all other cases. We do not believe it is the intention of the Commission to work an undue hardship on physicians or to imply that the physician must personally render all minor services, such as simple dressings, treatment for minor injuries, simple physical therapy, laboratory tests, etc, which may be done by well-trained nurses and technicians.

In our opinion, the Commission's attitude is that all services to injured workmen must be done under the direction of the attending physician and for which he is at all times responsible; that every physician keep in close touch with every case under his care; that he prescribe and supervise through oral or written instruction, the treatments being given by his office assistants; that he delegate to these assistants only work that they are qualified and legally permitted to do, and that he assume direct personal responsibility for the service rendered by his office aides.

In this connection, physicians should bear in mind that a physician signing a medical report for an injured man not personally attended by him or submitting a fee bill for services not actually performed by him or under his direct supervision may be prosecuted for fraud under the fraud section of the Workmen's Compensation Law.

The State Industrial Commission has endeavored constantly, we believe, to be fair and reasonable in the matter of compensating physicians for service to claimants. Undoubtedly, in interpreting and enforcing this regulation the Commission is expected to follow the same policy. Little difficulty is likely to arise in this connection if all physicians keep in mind that every physician has a personal responsibility in *all* cases handled by him and that all persons employed by him for office routine and to assist in treating patients must be competent and thoroughly qualified to perform the services expected of them.

COOPERATION IS ESSENTIAL

Some of the causes for delay in the payment of medical fees are directly chargeable to physicians themselves. A great majority of physicians are cooperating in a splendid manner with the Commission. However, there is a small number who have assumed a careless and uncooperative attitude, causing unnecessary confusion and delay in the Commission routine.

In some instances, physicians fail to furnish complete data or they submit inaccurate and confusing information. Frequently the settlement of a case has to be delayed pending voluminous correspondence with the physician to clear up conflicting data or obtain complete information on the case. This results in additional work for the clerical force of the department and slows up the routine, ultimately resulting in delay not only in particular cases but in all cases.

One of the more common errors committed by physicians, files of the Commission show, is in not adhering strictly to the adopted schedule of fees. Unless the case is unusual in nature and requires special treatment and attention, only the published flat rate fee for treatment can, under the rules of the Commission, be approved. However, the Commission has been lenient on this point and where a physician has been able to show that an unusual amount of necessary treatment and care were given, the Commission has usually been inclined to be generous and to make suitable adjustments in the fee.

Some physicians have a habit of charging for daily visits following an operation, which charge under the fee schedule is taken care of in the flat rate fee for operations and after-care.

In some instances, fee bills submitted to the Commission are not made out in chronological order—that is, the charges for daily visits are listed in one place and the charges for operations or special treatments in another, making it necessary for the examiner to spend more time than should be necessary in arranging the various charges according to dates and in otherwise checking the bill.

Some physicians fail to itemize properly their fee bills, necessitating correspondence from the Commission to the physician and delaying final settlement.

Frequently physicians are lax in prompt submission of fee bills. Of course a bill for medical services cannot be paid by the Commission until it has been checked. Obviously, it can't be checked until it has been submitted. Not long ago, the Commission had to refuse to pay a bill of approximately $800 submitted by a physician because it was not presented within 10 years from the time of the payment of the last compensation to the claimant, a statutory limitation provided in Section 1465-86 of the Workmen's Compensation Act.

Some physicians apparently believe the rules and regulations of the Commission can be ignored or violated on all occasions and that excessive fees can be charged because the state "foots the bill".

Officials at the department recently informed this committee about several cases where physicians and groups of physicians, clinics and institutions had rendered unnecessary special treatments and made elaborate examinations for minor injuries, apparently, simply to increase the size of their fees.

The net result of these instances has been that the physician, group or institution has not been compensated for the unnecessary and extravagant

service and has lost the confidence of the Commission. Naturally the Commission will hesitate to refer patients to these physicians, clinics and institutions when special examinations and treatments are actually necessary.

The standing of the entire medical profession before the Commission may be jeopardized by the unfair and unscrupulous attitude of a few physicians and groups. At the present time, the medical profession of Ohio generally is in an advantageous and favorable position in its relationship with the State Industrial Commission because of its cooperation generally with the Commission. It is the duty of every physician to respect this confidence by cooperating to the fullest extent and keeping his relationship with the Commission above all question.

The Medical Economics Committee kept in close touch with the Commission during the time the Commission was formulating a code of 17 rules and regulations relating to and governing practice and procedure before the Commission, pursuant to the authority given the Commission in Senate Bill 319, enacted by the Eighty-Ninth General Assembly, in order that the Commission might be properly informed on any medical angles which might arise in promulgating the rules and regulations.

These rules and regulations became effective March 1, 1932, and deal largely with the matter of whom shall be permitted to represent claimants and employers before the Commission; the conduct of hearings; regulation of fees to be paid agents representing claimants or employers; conduct of employes of the department; inspection of the Commission's files by persons other than employes of the Commission, etc.

Space will not permit a review here of other workmen's compensation questions considered by this committee. Some of these were discussed in articles published on the following pages of the 1931 Volume of *The Journal*, which should be considered a part of this report: Pages 67, 240, 312, 573, 577, 578, 725, 728, 731, 811, 886, 958 and 975.

The committee wishes to emphasize the fact that physicians in case of delay in receiving fees from the Commission or of misunderstandings, should deal directly with the Commission or submit the facts to the Headquarters Office of the State Association which has a cooperative arrangement with the Commission for reviewing claims for members of the State Association and which plan has the approval of the Commission. It should be unnecessary for physicians to place fee bills in workmen's compensation cases in the hands of collection or "service" agencies.

RACKETS AND SWINDLES

The past year has been a difficult period financially for the medical profession generally, due to the economic depression, the unavoidable extension of credit, and the increasing delinquency in the payment of accounts due physicians. Many physicians have been hard-pressed to meet current expenses, while all have witnessed a large increase in the number of unpaid bills.

As a result many physicians have doubled their efforts to collect long overdue accounts and obtain something on account from persons who were not indigent or in destitute circumstances.

This has paved the way for an unusually energetic campaign among physicians by representatives of collection agencies and "service" organizations, offering all kinds of schemes for the collection and adjustment of outstanding accounts. Many of these agencies are fly-by-night and questionable concerns whose chief object is to tie up the physician by a tricky, misleading contract, then swindle him out of most of the money collected or attempt to collect from him a commisison for service which they failed to render.

Of course, there are some collection agencies which are reputable and dependable. These firms usually are well known; are operated by local individuals, and have established headquarters.

Unfortunately quite a few Ohio physicians have fallen for the ballyhoo of irresponsible collection agencies and have paid dearly for the experience. Furthermore, a number of physicians have had considerable difficulty with some casualty, health, and accident insurance companies, with little or no national rating, which represent themselves as catering to professional men, especially physicians. The chief talking points of solicitors for these companies are: low premium rates and liberal amounts paid in settlements. In most instances, however, these companies have been unable—at least have shown no desire—to make good on a majority of claims filed with them.

Of course, physicians should not confuse these racketeering companies with well-established, high-grade and reputable insurance firms, having a sound financial rating and a reputation for prompt and satisfactory service.

In dealing with collection agencies, insurance companies, salesmen of all kinds, and in making financial transactions of any kind, physicians should adopt a "show me" attitude, and should by all means investigate carefully and thoroughly before they invest in or contract for the service or product offered.

Numerous warnings concerning gyp and swindle schemes and rackets of all kinds have been published from time to time in *The Journal*, the more recent articles appearing in the November, 1931, September, 1931, November, 1930, October, 1930, July, 1930, March, 1930 and October, 1929, issues. This committee recommends that physicians be wary and cautious in their financial dealings and for their own information and benefit, re-read the articles cited.

COOPERATION WITH A. M. A.

The Committee on Medical Economics has been very much interested in the activities which have been inaugurated by the new Bureau of Medical Economics of the American Medical Association. We believe a bureau or agency of this kind has long been needed in national medical organization. It promises to play a big part in attempts to solve and adjust numerous and vital medical economic problems.

The Committee on Medical Economics, in cooperation with the Committee on Public Policy and the State Headquarters Office, has endeavored to cooperate as fully as possible with the A.M.A. bureau in assembling authoritative information and data from Ohio on many economic questions. On several occasions, lengthy reports on Ohio angles to medico-social questions have been sent to the bureau which is assembling all the authoritative data available on such questions.

At the suggestion of the Committee on Medical Economics and the Committee on Public Policy, the A.M.A. bureau has given up the idea of sending multiple questionnaires in a medical economics survey to the various county medical societies and academies of medicine in Ohio. It was pointed out by the committees that multiple questionnaires to county medical societies on such complex and controversial questions as dispensaries and clinics, collections, contract practice, group practice, industrial medicine, sickness insurance, etc., would undoubtedly be confusing; might not be uniformly applicable to all the counties, and could not be uniformly answered.

It was suggested that questionnaires and inquiries of this sort be sent to the Committee on Medical Economics of the State Association, which, in conjunction with the Committee on Public Policy and the State Headquarters Office, could supply the Bureau from time to time with information which has been or could be obtained and would give a comprehensive general picture of social and economic conditions in Ohio affecting the medical profession and the practice of medicine.

* * *

In conclusion, this committee believes it is obvious that the serious and complicated social and economic questions, some of which have been touched on in this report, affecting in many ways the medical profession, individually and collectively, cannot be solved by a few individuals and groups. Some may never be solved; others may be solved, particularly so by concerted action on the part of the medical profession as an organized group; and, still others may be adjusted through social evolution over which the medical profession can, and should, increase its influence.

Considerable has been accomplished in the past due to the wholehearted and united cooperation and interest of the individual members of the State Association and of the component county societies, working in conjunction with the officers and Committee on Medical Economics, as well as other state committees. Much can be accomplished in the future if the same cooperation and active interest are maintained. Keep this committee informed about your problems. Make the State Headquarters a clearing-house for social and economic questions. Above all, realize that your officers and committees depend on you for constructive advice, suggestions, and cooperation.

Annual Report of The Publication Committee

ANDREWS ROGERS, Chairman, (1934) Columbus
GILBERT MICKLETHWAITE, 1932) Portsmouth
A. B. DENISON, (1933) Cleveland
DON K. MARTIN, Secretary Columbus

As in the past your Publication Committee believes that *The Journal* itself is the best and most complete report of its efforts. However, a reference to some of the details and problems of publication may not be amiss. We are especially anxious to have the suggestions and cooperation of the membership in order that the value of *The Journal* constantly may be increased.

In view of the fact that *The Journal* is a consecutive record of many matters of direct interest to every physician, we make a special plea that each member not only read his copy each month, but keep for ready reference a complete file of each year's issues; preferably in bound volume if possible.

The Ohio State Medical Journal made its initial appearance as a regularly issued periodical 27 years ago next July. During this period of almost three decades, *The Journal* has developed rapidly until today, we believe, it ranks among the foremost publications of its particular type and plays an indispensable part in the activities of medical organization in Ohio.

Many of the ideals and objectives which we have endeavored to attain in the publication of the *Ohio State Medical Journal* are similar to those which Dr. Frank C. Hammond, editor of the Pennsylvania Medical Journal, believes would assure the publication of an "ideal state medical journal". Dr. Hammond in a recent paper on "The Relation of the State Medical Journal to the State Medical Society", listed some of the functions, aims and purposes of a state medical journal as follows:

"The State Medical Journal in its relation to the State Medical Society should do certain definite things. The ideal State Medical Journal is the one which best reflects the highest ideals and aspirations of the profession within the territory

it serves. It must report the activities of the State Medical Society which publishes it, and keep its readers in touch with the work of the organization and of their fellow members. It must advise them of the activities of other related organizations, both within and without the state and within and without the profession. It must report the current scientific developments throughout the world with especial emphasis upon those which occur within the state. It must represent the interests of medical folk in the scientific, economic, educational, organizational, legislative, and welfare phases of the practice of medicine. It must be cooperative, not individual. It must preserve current medical history for the benefit of future historians, and must make this available by satisfactory indexing. It must help to educate its readers in up-to-date methods. It must maintain the highest scientific and advertising standards. It must preach progress and improvement and righteousness wthout ceasing. If it is to be a power in the profession, it must lead, not follow; inspire, not reflect; educate, not merely entertain. And if it is to do all these things, it must preeminently be interesting, attractive in appearance, and well edited from a literary standpoint.

While we do not believe that *The Ohio State Medical Journal*—any medical journal, in fact—measures up in every particular to the large order Dr. Hammond has suggested, your committee is of the opinion that a great many necessary and desirable functions for the benefit of the medical profession and the public health of Ohio generally are being performed by *The Journal* and that noteworthy progress toward the "ideal" is being made.

During the past twelve months *The Journal* has presented over 1000 pages of informative text. An effort has been made to correlate all the material published in orderly and readable form, with special attention to accuracy and simplicity.

Approximately 100 original scientific papers, many of which were presented before the various sectional meetings at the last annual meeting and some of which were submitted directly to this committee, were published in *The Journal* during the past year. Each manuscript was given thorough scrutiny by the committee, being judged from the standpoint of scientific value, literary style and general interest. A system of double editing was employed by the committee in reviewing the papers submitted in order to minimize errors and obtain clarity and brevity.

The committee in its editorial capacity has consistently and conscientiously judged each paper submitted for publication solely on its scientific and literary merits, and on its value to the readers, which, the committee believe, are of far more importance, in the final analysis, than the public reputation of the author. The committee has found it necessary to reject several papers during the past year because they did not measure up to the standards which have been set for articles published in *The Journal*.

The committee found it necessary to reject several papers because they had been published previously in other periodicals or in pamphlet form for personal distribution by the authors before being submitted for publication in *The Journal*. Under the By-Laws of the State Association, all papers read at the annual meetings of the State Association are the property of the Association and shall not be published as original elsewhere, nor until after they have been published in the *Ohio State Medical Journal*.

Several papers submitted by Ohio physicians who were not members of the State Association were rejected, the committee feeling that since non-members are not permitted to enjoy the privileges of the State Association, it would be inconsistent for the committee to permit non-members to use the columns of *The Journal* for scientific presentations.

The attention of the members is called to the fact that a card index of authors of scientific articles published in *The Journal*, as well as an index of scientific articles by title, are kept at the headquarters office of the State Association for the convenience of members seeking information about authors, titles and dates of publication of articles which have appeared in *The Journal*.

Due to the rapid increase during the past few years, especially during the past twelve months, in the number of important problems affecting medical practice, scientific medicine and public health, one of the primary and essential functions of *The Journal* has been to discuss and analyze many of these serious economic, social, governmental, legislative, ethical and public health questions.

Comments and criticism made on such matters have been based on the fundamental policies of the State Association, as laid down by the House of Delegates at various times, and on the recognized principles and ethics of the medical profession.

Many special articles have been published on legislative and governmental developments; legal and court opinions; new regulations and laws of special interest to the medical profession; activities and programs in the general fields of public health and social welfare; the organized activities of allied and related groups and organizations, as well as the work carried on by the officers, councilors and committees of the State Association.

No physician should ignore the trend of the times or fail to keep himself accurately and thoroughly informed, not only on scientific matters but on all developments which affect the practice of medicine or the social-economic life of the profession. The material presented in *The Journal*, we believe, affords every physician an opportunity to keep in touch with such events and developments, and of their significance as judged by the policies of the State Association and the principles of the medical profession.

Each month *The Journal* has carried numerous news notes and personals concerning Ohio phy-

sicians. It has endeavored to keep the members informed about the activities of the hospitals of the state.

Due to the splendid cooperation of the secretaries and correspondents of many of the county medical societies and academies of medicine, the section of *The Journal* devoted to reports and announcements of county society and academy meetings, and various sectional meetings, has grown and expanded until it now comprises one of the principal and most interesting departments of *The Journal.*

Your committee is especially anxious to develop this department to a point where an official report or announcement from every county medical society and academy will appear regularly in *The Journal.* Obviously, this goal cannot be reached unless every county society secretary or designated correspondent cooperates and furnishes the material for publication. Articles for *The Journal* should be mailed to the headquarters office of the State Association, where news for *The Journal* is assembled. The material should reach the headquarters office if possible not later than the twelfth day of the month preceding the date of publication which is always on the first day of the month.

The Committee on Publication has always felt that style and make-up are important factors in stimulating reading interest. We have endeavored to make *The Journal* attractive in appearance and easy to read. Clean-cut, readable type is used throughout. A good quality of heavy paper has been found desirable, especially because it makes each copy durable and the binding of copies in volumes practical.

Style and make-up are largely questions of personal preference on the part of the publishers of any periodical. However, your committee welcomes suggestions on this phase of its work, as well as any other matter under the direction of the Committee on Publication. Members who have suggestions and criticisms about *The Journal* should consider it their privilege and duty to give the committee the benefit of their judgment and advice, for *The Journal* belongs to the membership; it is their publication, and it should conform to the will of the majority.

We strongly urge every member to read the advertisements published in *The Journal.* Any concern able to pass the strict advertising tests maintained by *The Journal* deserves the cooperation and support of the members of the State Association. Every advertisement before it is admitted to the columns of *The Journal* must have been approved by the committee, the Cooperative Advertising Bureau of the American Medical Association, and often the A.M.A. Council on Pharmacy and Chemistry. All are judged from the standpoint of the quality and scientific value of the product or products advertised; the accuracy of the claims made by the advertiser, and the style and dignity in which the material is presented. Regular advertising rates for various classes of advertising have been established and the committee, acting under the instructions of the Council, will not accept advertisements of any character on a contingent or percentage basis.

In view of the uncertainty of advertising revenue to *The Journal* during the current year, because of unsettled business conditions, the Committee on Publication has held several conferences with the Committee on Auditing and Appropriations and has arranged for publication of *The Journal* on an even more economical basis than has been maintained for the past few years. A satisfactory contract on printing has been made. A slight reduction in the size of *The Journal* may be made to "balance" with advertisements, although adequate space will be provided each month for the publication of the usual number of scientific articles and news and information of timely interest and of importance to the membership at large. An effort is being made to economize by minimizing routine expenses.

In conclusion, your committee takes this opportunity to express its appreciation of the widespread cooperation which has been accorded it during the past year, as in previous years, by the members of the State Association. We believe that *The Journal* is a most essential factor in the organized activities of the Association. It should be read carefully each month by all members, for as Dr. Fishbein has said, "the man who gets a scientific journal or the journal of a state medical society and fails to read it is the man who needs to read it most". Members should contribute to it if they have something constructive and interesting to offer. Some of the most valuable special articles published in *The Journal* in past years have been suggested by physicians who are informed on current problems and have sensed the benefits which might arise from publication of an article on the subject. *The Journal* has progressed because the membership has cooperated with those whose duty it is to edit and publish it.

A reunion of medical graduates of Ohio State University who will attend the annual meeting of the American Medical Association at New Orleans, the week of May 9, is being planned, according to an announcement by John B. Fullen, secretary of the Ohio State University Alumni Association, Columbus. Ohio State graduates attending the A.M.A. meeting are requested to watch for an announcement which will be made during the meeting relative to the time and place of the Buckeye reunion.

Applicants for licenses to practice medicine and surgery, and limited branches of medicine, in Ohio will be examined by the State Medical Board in Columbus on June 7, 8, 9 and 10.

Annual Report of The Committee on Medical Defense

J. E. TUCKERMAN, Chairman, (1934) Cleveland
F. P. ANZINGER, (1932) Springfield
W. H. SNYDER, (1933) Toledo
DON K. MARTIN, Secretary Columbus

Statistics from various sources, including experience of insurance companies, show that there has been a definite increase during the past few months in the number of suits and threats against physicians for alleged malpractice.

More than ever before has it become apparent that the medical defense plan of the State Association, established in 1916, to safeguard the medical profession as a whole against unjust and malicious malpractice suits, is an exceedingly important activity of medical organization.

As evidenced by the record of the past year any plan or program for the prevention of malpractice suits will avail little as long as some members of the medical profession fail to give their wholehearted support and cooperation. Despite suggestions for "prevention", the "malpractice damage suit industry" is still entirely too active in Ohio.

An attorney recently in an address before a medical gathering made the following significant comment, based on long years experience in defending physicians against suits for alleged malpractice;

"If doctors," he declared, "were a little less critical of each other's work, a little less given to currying favor with their patients by off-hand condemnation of the prescriptions or the work of previous medical attendants, often without knowing the facts and circumstances under which such prescriptions were given or the professional service rendered, fewer of their professional brethren would be the subjects of damage suits and fewer of them would be called to the stand to explain what they meant by such off-hand and ill-advised criticism, which is often the first inspiring cause for the lawsuit which follows."

The Committee on Medical Defense repeatedly has emphasized this very point to members of the State Association. However, a review of the committee's record for the past year reveals that there are some physicians in Ohio who have failed to heed this pertinent advice and have not as yet acquired the commendable habit of guarding their tongues, *especially when commenting on their fellow practitioners.*

CAUSES OF SUITS

A considerable number of the suits and threats of suits reviewed by your committee during the past twelve months were inspired by or received some impetus from the intimations, thoughtless or critical remarks of some physician concerning a colleague or the latter's professional skill.

Obviously, as long as this condition exists, the committee's efforts to minimize suits and threats of suits for alleged malpractice and to eliminate unjustified and malicious suits and threats will fall short of fulfillment. Why a few physicians persist in making uncomplimentary and disparaging remarks concerning other physicians, is beyond understanding, especially when such remarks have been found to be the primary cause of more than 75 per cent of suits for malpractice.

Nothing has occurred during the past year to change the belief of your committee that practically all civil malpractice suits are not justified by the facts; and are instigated for the most part by disgruntled individuals purely for gain, or initiated by unscrupulous or complaisant attorneys.

While in an occasional suit charging malpractice there is fairly reasonable evidence of carelessness or negligence on the part of the defendant physician, such suits are exceedingly few in comparison with the large number instigated for the purpose of "bleeding" the physician, or in a spirit of revenge to annoy or injure his professional reputation.

Although the great majority of suits which come to trial are not sustained in the courts, the notoriety attending such suits is never pleasant for the defendant and always reflects upon the standing of the entire medical profession. It is important to prevent the instigation of such suits for they are prone to become epidemic in nature. One suit is often the forerunner of and the suggestion for other similar suits against physicians in the same community. The physician whose careless, thoughtless or malicious remarks may have inspired a suit against some colleague has no assurance that he will not be the next victim.

LEGAL LIABILITY

There is little danger of a physician furnishing any just reason for the filing of a suit for alleged malpractice against him if he has a thorough understanding of the obligations which he assumes when he undertakes to care for a patient and carefully observes certain fundamental principles of medicine and law in his relationship with the patient:

Legally, a physician is not required to take a case unless he so desires. If he accepts the employment, he contracts to bring to it the average degree of skill, care and diligence exercised by the members of his profession in the same and similar locations or localities, in the light of the present state of medical science. He cannot abandon the case without cause or without proper notice to the patient. He must follow the approved methods of treatment, and if there be more than one approved method, he must use his best judgment in determining which method to follow. He must give the patient proper instructions as to the care, attention and caution to be exercised by the patient in his absence. He must attend with sufficient frequency and it is for the physician to determine when no further attention is required. He must use care in the selection of his assistants, or of another to perform

an operation which may be necessary. He is liable for the acts of his assistant or for another employed by him, so long as they are jointly engaged, and is liable for the acts of his assistant or intern acting under his direction. Only persons thoroughly competent by reason of education and experience should be employed by him to assist him in the care of patients.

MEDICAL DEFENSE NOT INSURANCE

One thing should be clearly understood by every member of the State Association and that is: *The medical defense plan is not*, and should not be considered, *insurance*, as this term is applied to indemnity.

Court judgments cannot be paid out of the funds of the Association. It is entirely up to the individual physician whether or not he wishes to carry indemnity insurance against malpractice. Many physicians do; many do not. If a physician decides to indemnify himself in this manner, it is quite important that he insure himself in an indemnity company of sound financial standing and with a reputation for honest and fair dealings.

Although the medical defense plan regulations bar the State Association from paying court judgments in any case and contributing to the cost of engaging legal counsel when the case is conducted by an insurance company, the medical defense plan is of inestimable value and affords valuable protection to all physicians.

Aside from providing machinery for emphasizing precautionary measures and methods of preventing malpractice suits, the defense plan permits the Committee on Medical Defense to offer every assistance possible to facilitate the preparation of the defense, even of physicians whose cases are being handled by insurance companies. Corroborative testimony is available. Assistance in the preparation of briefs is offered, along with advice and suggestions gained from experience in similar cases. Also, the defense plan protects the member should any question arise as to his rights under a particular policy in that he can look to the counsel of the State Association for advice and assistance.

Furthermore, the defense plan is elastic enough to permit the Committee on Medical Defense to participate in any suit, whether handled by indemnity companies or not, when principles of law affecting malpractice actions are at stake or where a judicial interpretation has not been made on a particular point, or where an adverse decision in a suit would establish a precedent involving the interests of the entire profession. The Committee on Medical Defense always has insisted that all unjust suits should be fought through to the last court, if necessary, to protect the individual physician and the profession against unwarranted actions and accusations. This policy of the committee has had considerable influence with indemnity companies and has minimized efforts on their part to compromise suits regardless of the facts or effect on the reputation of the physician.

In fact, insurance companies which write indemnity insurance against malpractice welcome the help and advice of the Committee on Medical Defense and realize fully the additional protection and assistance offered by the medical defense plan of the State Association. Some of these companies, realizing the importance of membership in medical organization for the physician professionally, are refusing to issue a malpractice indemnity policy to any physician who is not a member of his county medical society and the State Association.

It is evident that the medical defense plan (which is neither indemnity insurance nor a substitute for it), is vital and important to every physician and to the profession at large and worth many times its cost; even if all members should decide to carry indemnity insurance with companies which issue such policies.

FUNDAMENTAL REGULATIONS

Under the rules and regulations of the medical defense plan, there are certain instances in which the State Association is barred from assisting in the defense of a member in addition to those already cited.

The Association will not contribute to the defense of a member if:

1. The alleged cause of the suit occurred or the suit was filed during a period for which the member is or was in arrears with his dues, or in case the alleged cause occurred previous to the defendant's membership in the State Association. Annual dues in the State Association are always due *in advance* on or before January 1.

2. He has failed to forward a medical defense application blank, properly filled out, to the State Association offices within ten days after the service of summons.

3. He does not take, or have taken and keep on file, or have available, *X*-ray pictures of fracture cases, unless it can be shown that at the time and place it was impossible to secure an *X*-ray plate.

4. He has been sued on "cross complaint", by filing a suit to collect a bill within one year of the termination of his services.

5. He is believed guilty, after careful investigation, of illegitimate professional actions or service.

When sued or threatened with suit, a member should immediately notify the Executive Secretary, Ohio State Medical Association, 131 East State Street, Columbus, Ohio, requesting medical defense blanks. Upon the receipt of these the member should furnish the information requested in duplicate, sending one of these completed blanks to the chairman of the Committee on Medical Defense, Dr. J. E. Tuckerman, Osborn Building, Cleveland, Ohio, and the other to the State Association offices.

Provided the physician sued is eligible to defense under the rules and regulations of the defense plan, the committee engages the necessary legal talent and makes every possible effort to

carry his defense to a successful termination. Designation of local attorneys and their employment is entirely in the hands of counsel for the committee, which will not contribute to the expense of legal services unless the attorneys are approved by that counsel.

When the defense is conducted by the State Association members of county medical societies, without thought of pecuniary return, should give not only their moral support, but also take an active part in the conduct of the trial of a colleague in any way they can best assist.

A SUMMARY OF SUITS

The economic factor involved in the medical defense plan of the State Association is of great importance from the standpoint of the membership generally. Since the medical defense plan has been in operation, the following suits and threats of suits have been filed with this committee:

Year	Suits	Threats
1916-1920, inclusive	53	43
1921	18	9
1922	15	15
1923	10	10
1924	14	7
1925	13	10
1926	18	16
1927	10	9
1928	21	7
1929	23	16
1930	16	17
1931	19	20
1932 (Jan. to March)	4	4
Total	234	173

Estimating the judgment sought in each suit filed against members of the State Association during the past 16 years at $10,000, it will be readily seen that the aggregate of damages sued for would be considerably over two million dollars.

BASIS OF ACTION

Some idea of the basis for many of the suits filed and threats made against physicians is obtained from a study of the records for 1931. Suits and threats in general were occasioned through one or more of the following causes:

Ill-advised and unjustified comments of colleagues, which is the most serious and primary cause.

Hope of dissatisfied patients and plaintiff attorneys to profit.

Desire to injure defendant's professional reputation.

Criticism by relatives and friends of the patient.

Carelessness and negligence of defendant, superficial examinations and service.

Failure to keep accurate records.

Negligence of assistants.

Failure of patient or family to carry out defendant's instructions and advice.

About 50 per cent of these cases were fracture or suspected fracture cases and a large proportion of the patients who sued or threatened to sue were indigents or near-indigents.

In conclusion, this committee urges the various county medical societies and academies of medicine, as well as individual physicians to take an active interest in this important work of preventing and discouraging unjustified suits for alleged malpractice. County societies can do much good by holding discussions frequently on this question. Individual physicians can assist materially by keeping always in mind the "causes and effects" repeatedly emphasized by the Committee on Medical Defense. Cooperation and careful observance of the principles and suggestions outlined in this report will go far toward minimizing this menace to the professional standing of every physician in Ohio. It should always be remembered that "Talk *is not* cheap; but silence *is* golden".

Annual Report of the Committee on Medical Education and Hospitals

BEN R. MCCLELLAN, Chairman, (1934) ..... Xenia
R. H. BIRGE, (1932) ..... Cleveland
JOHN F. WRIGHT, (1933) ..... Toledo
DON K. MARTIN, Secretary ..... Columbus

The past year with its perplexities has been an opportune time for the study of the social aspect of medical practice, to determine, if possible, the part medical education should play in preparing the medical graduate to cope with social and economic problems, as well as scientific questions, in the active practice of medicine.

Dr. Stephen Rushmore, Boston surgeon, in his essay on "Some Aims of Medical Education", declares that "the aim of medical education is to educate men and women to become good doctors" and elaborates on this simple formula to say, in effect, that the good doctor must be possessed of something more than a superior knowledge of scientific data, definitions and technical facts. He also makes the pertinent statement that "medical education is, after all, largely education, and education refers to a process of growth and not to a state of passive receptivity".

Concerning education generally, Cardinal Newman makes this contribution:

"The man who has learned to think and to reason and to compare and to discriminate and to analyze, who has refined his taste and formed

his judgment, and sharpened his mental vision, will not, indeed, at once be a lawyer, or a pleader, or an orator, or a physician, or a good landlord, or a man of business, or a soldier, or an engineer, or a chemist, or a geologist, or an antiquarian, but he will be placed in that state of intellect in which he can take up any one of the sciences or callings I have referred to, or any other for which he has a taste or special talent, with an ease, a grace, a versatility, and a success, to which another is a stranger."

Much success has been attained in eliminating inequalities in scientific and technical phases of the medical education system. Ways and means for the selection of well-qualified applicants have been devised. The evils of standardization and rigidity in the medical curriculum have been minimized. A correlation of the subjects taught has taken place in many schools. Duplication of teaching effort has been eliminated. Clinical hours have been increased; didactic hours decreased. Greater emphasis is being placed on basic courses; less on the specialties. Students are being encouraged to undertake "self education". Numerous additional changes and modifications have been effected.

On the other hand, we believe that an equal amount of success has not been accomplished in preparation of the student to meet social and economic questions, the answers to which are not found in textbooks, clinical training or in laboratory analyses.

FACING SOCIAL PROBLEMS

For these reasons, and others, medical schools are faced with the responsibility of producing physicians efficiently trained in the medical sciences and also with an understanding of how to meet social and economic crises as they arise.

This idea was clearly expressed in an address made by Dr. Charles P. Emerson, dean of the Indiana University School of Medicine, at the 1931 Annual Congress on Medical Education, Medical Licensure and Hospitals. Commenting on the responsibilities of medical educators, Dr. Emerson said:

"Granting the truth of this general proposition that medicine is an excellent mirror of its contemporaneous culture, it becomes our duty as teachers to study the general trends in the business and industrial worlds of which our medical graduates soon will become a part, and see how these may affect their medicine."

Dr. Emerson pointed out the unfortunate trend on all sides which places undue emphasis on the virtue of highly developed organizations as a means of mass production, referring especially to the development of medical clinics and group practice on a large scale, many of which, he declared "illustrate only too well that fine organization with a view to mass production is not of itself a guarantee of the quality of their professional work".

"It is not surprising," he said, "that medical students are caught in this dominant trend of the industrial and business world. They admire large hospitals with well-organized staffs, with many and well-equipped laboratories, each with many well-trained technicians. Their ideal surgeon is he who performs fifteen major operations in one morning, on patients whom his assistants have studied and labelled but whom he himself has scarcely seen. Their ideal medical consultant is he who merely meets the new patient, turns him over to a staff of assistants and technicians and sees him next ten days later. From a mass of records on his desk he then makes the diagnosis and outlines the treatment. This may be wonderful business, but it is vicious medicine and surgery, and one of our first duties to our medical students is to impress upon them by word and by example the importance of the individuality of the patient; to show them that since no two individuals are alike, no two cases of the same disease can be just alike, and so none should receive standardized treatment. Human beings cannot be treated like homogenous steel and wood. Good medicine and good surgery demand the careful study of the individual patient's physical, psychical and social problems. * * * Fine organization with a view to mass production may succeed in the business world, but good medicine demands individual attention; retail business; bench work. To teach this to our students is our duty."

Dr. Emerson also deplored the emphasis which is placed on the machine, declaring that many students believe that diagnosis is a question of laboratory examination; that laboratory findings have a certain authority, a finality which physical examinations lack.

"Our laboratories furnish us with a wealth of valuable, even indispensable information, but the evaluation of each detail of this information for the case then at hand is a problem which only the one who knows the patient, his history, and his physical examination, can decide," he said.

"One of the most marked characteristics of modern medicine," he added, "is the rapidity of the stream of its progress. Are we teaching students how to keep abreast of the times in even one current of this rapidly flowing stream? Unfortunately, the majority of our graduates will, twenty years from now, be found to be practicing the medicine of their commencement year. There is special danger of this if they were unfortunate enough to be very successful the first two or three years of their practice."

LEARNING THROUGH EXPERIENCE

Your committee also calls attention to the trend in many parts of the country back to the old preceptorship system or a modified system similar in nature in order to give the undergraduate some fundamental training in the art of applying knowledge obtained in the classroom and laboratory.

To be sure, there are disadvantages as well as advantages in any such program but there is a growing opinion among medical educators generally that something of this nature should be undertaken by medical schools and that the benefits to be derived by the student may offset any flaws in such an arrangement.

One proponent of preceptorial training has summaried the advantages of such a system as

follows, basing his conclusions on interviews with students who have had such training:

1. The student is acquainted with the facilities and methods of the general practitioner.

2. He gets an idea of the variety of cases seen in general practice.

3. He learns how to supply hospital methods and modifications thereof to general practice.

4. The necessity of producing results regardless of theory is emphasized many times.

5. The student becomes acquainted with more useful drugs and medicines.

6. He is afforded an opportunity to observe the attitude and manner of the doctor toward his patients.

7. H learns the value of keeping abreast with the progress of his profession.

8. The student observes the position of the doctor in civic, social, religious, and political life of the community.

9. Many phases of medical economics are taught to the student.

10. The student observes disease in the office stage; that is, the incipient stage which is seldom seen in hospital instruction.

POSTGRADUATE STUDY

Obviously medical education has obligations in addition to that of training the undergraduate. We believe that one of the primary duties of medical education is to assist in making good doctors, already in practice, better doctors. That is, to devise opportunities for physicians to keep abreast of current knowledge and methods in medicine; to acquire training in the specialties, and for periodic instruction on newer methods used in general practice.

Speaking of the value of graduate study, Dr. Henry A. Christian, Hersey professor of the theory and practice of physic, Harvard University Medical School, offered the following pertinent observations:

"Things in nature rarely are static; they increase or they decrease; they grow or they decay; they progress or they retrogress. Man's education in many respects resembles things of nature; rarely is it static; when knowledge does not increase, almost always it decreases. Physicians should remember this and make every effort to keep out of the static state and on the side of increase, of growth, of progress.

"Physicians can be divided into two great groups, those that are learning and those that are forgetting, those that each year know more and those that each year know less. There seems no third group, those that are stationary. A few physicians increase in knowledge from within and grow from their own doing. These are the innate investigators. The rank and file require outside help to grow and to progress. Books, meetings, contacts, discussions, teachers are our armamentarium for progress. Like the 'spring tonic' of past days, all of us need some of this medicine, at least annually, better if it comes more frequently. A large majority of physicians know their need and seek treatment. Postgraduate instruction is a potent prescription to this end, if it can be carried to the proper dispenser for filling. Postgraduate instruction should commence with the physician's graduation from the medical school. It should continue throughout his life. Many varieties of postgraduate instruction should be, and in fact are, available to meet the several needs of medical men."

The several phases of postgraduate education now are receiving enthusiastic attention from medical educators generally. Most of them are agreed that it is inseparably associated with the problems of medical service and medical practice, as well as medical education.

In this connection, it should be noted that there is a growing belief that training in the specialties should become essentially a part of postgraduate education. The demand that special identification should be created for those who profess to be specialists, such recognition to be granted only on evidence of the successful completion of a training which in the opinion of competent medical advice is adequate to prepare the physician for practice in a limited field, has stimulated the desire on the part of many men in active practice for further training in their chosen specialty. Many schools, in fact, most of them, are placing less emphasis on instruction in the specialties for undergraduates and greater emphasis on basic subjects and general medicine.

Dr. Williard C. Rappleye, dean of the College of Physicians and Surgeons, Columbia University, makes the following prediction concerning graduate education:

"The continuation education of physicians is synonymous with good medical practice, and provisions will be made ultimately whereby every physician will be able to continue his education. * * * * Possibly, we shall some day see the medical profession in this country possess a dual objective and organization, one for medical service and a parallel one for postgraduate medical education. Without doubt, the hospitals scattered throughout the country will become important factors of this program and we may look forward expectantly to the time when we shall see subsidiary medical centers scattered over the length and breadth of our country—the entire network affiliated with university centers from which physicians, technicians, nurses, dentists and other trained personnel will move outward in a process of infiltration of the community through subsidiary centers."

The effect the development of postgraduate education is having and will continue to have on undergraduate medical training is pictured by Dr. Rappeleye:

"These various considerations have more important relationships to the basic medical course than most of us appreciate," he declares.

"If we are to devise means of continuing the education of physicians in practic, and to require special training, and possibly, separate licensure for specialists, we must modify, somewhat, our conception of the purposes and methods of the medical course itself. The basic medical course will devote itself in the future even more than it does now to the laying of sound foundations on which later continuation education can be

built. * * * We recognize that all true education is self-education and in the more progressive medical schools, serious attention is given to training students in sound methods and habits of study which will give them a permanent intellectual equipment which will prepare them to continue their self-education throughout their professional lives.

"The degree to which medicine will occupy its proper place in modern society depends on professional leadership and the extent to which the rank and file of the profession are able to keep abreast of medical knowledge."

MEDICAL EDUCATION IN OHIO

Ohio's place in the field of medical education is well known to members of the profession. The state's three Class A medical schools rank among the leaders in undergraduate medical training. This was forcibly revealed in the article published in the October, 1931, issue of *The Ohio State Medical Journal*, which reviewed the work and programs at these schools at the beginning of the current school year; and to which this committee refers as a part of its present report.

It may be safely said that no Ohio youth need leave his native state to obtain medical training of high caliber. However, your committee feels that Ohio's medical schools might consider the question of providing still more extensive facilities for postgraduate medical education. True, considerable and valuable work along this line is already being done by the three Ohio schools. Secondly, your committee believes that every county medical society in the state should take an active interest, stimulating among its members the urge for continuous self-education.

IMPORTANT ROLE OF THE HOSPITAL

It is impossible to consider the question of medical education without recognizing immediately the important role which the modern hospital plays in this and many other phases of medicine. There is a distinct relationship between hospitals and medical education. The problems of hospitals are closely interwoven with the problems of medical service, medical practice and medical education.

Hospital internship is recognized as one of the most important steps in the education of the physician. Leaders in medical education are unanimous in their opinion that most potent postgraduate clinical instruction is afforded in a well-organized, efficiently-operated hospital; both for the recent graduate and for the physician who has been in practice.

Some medical schools have even gone so far as to delay awarding degrees in medicine until the student has successfully completed at least one year's internship in an approved hospital. A few states demand the hospital internship of the applicant for a license. Statistics show that graduates of the best medical schools with rare exceptions seek service in a hospital following graduation.

TRAINING THE INTERN

The responsibility for the proper functioning of any system of intern training is divided among the medical instructors, the hospital management, the hospital staff and the intern himself. These several functions are self-evident and require no elaboration.

The important part which the medical and surgical staffs play in any system of intern training cannot be overemphasized. Their responsibilities are summarized in excellent fashion by Dr. Harold L. Foss, chief surgeon at the Geisinger Memorial Hospital, Danville, Pa., in a recent address on "The Hospital Training of Interns."

"Irrespective of how well organized the intern service may be and of how great the effort put forth by the heads of departments to render the training of practical value," according to Dr. Foss," the greatest accomplishment will not be achieved without a certain basic principle being borne in mind. The young doctor fresh from the medical school and entering his intern service begins now to practice more of the science than of the art of medicine. He is in the most formative period of his existence, keen to learn, relying tremendously on the guidance of his chiefs, so much so that it places a great responsibility on them, the significance of which, I fear, none too frequently bear in mind. We should fully appreciate our obligation as teachers, realizing that our role is hardly second in importance to that of the men who have guided the student during his college years and that it is our privilege, perhaps more than it was theirs, by our precept and example, by our opportunity to stimulate his latent enthusiasm, by the inspiration of our own personalities to afford him in the most important phase of his professional career that guidance so important in molding and shaping and directing his destinies to the end that his life becomes a failure or a success largely as we choose to make it."

Obviously, every hospital is not a suitable place for intern training. In order to protect the medical school graduate and to standardize in a way hosiptal intern service, the Council on Medical Education and Hospitals of the American Medical Association has for a number of years made an extensive annual survey in the hospital field to determine what institutions offer the proper facilities for internships.

Institutions approved for intern training must conform to certain standards and possess certain facilities, chief of which are: Adequate supply of the various types of clinical material; an organized, ethical staff; laboratories under competent medical supervision; available library facilities; require complete clinical charts; perform necropsies on 15 per cent of deaths occurring in the hospital, and impose regulations governing intern conduct and duties.

OHIO'S APPROVED HOSPITALS

At the time of the last report of the A. M. A. Council (August 15, 1931), there were 674 hospitals in the country, with 211,299 beds and offer-

ing 6,154 internships, which had met these conditions and were approved by the Council.

Of this number 36 were Ohio hospitals, namely:

City Hospital, Akron; St. Thomas Hospital, Akron; Mercy Hospital, Canton; Bethesda Hospital, Cincinnati; Christ Hospital, Cincinnati; General Hospital, Cincinnati; Deaconess Hospital, Cincinnati; Good Samaritan Hospital, Cincinnati; Jewish Hospital, Cincinnati; St. Mary Hospital, Cincinnati; Charity Hospital, Cleveland; City Hospital, Cleveland; Lakeside Hospital, Cleveland; Mt. Sinai Hospital, Cleveland; St. Alexis Hospital, Cleveland; St. John's Hospital, Cleveland; St. Luke's Hospital, Cleveland; Woman's Hospital, Cleveland; Grant Hospital, Columbus; Mt. Carmel Hospital, Columbus; St. Francis Hospital, Columbus; University Hospital, Columbus; White Cross Hospital, Columbus; Miami Valley Hospital, Dayton; Elyria Memorial Hospital, Elyria; Mercy Hospital, Hamilton; City Hospital, Springfield; Flower Hospital, Toledo; County Hospital, Toledo; Mercy Hospital, Toledo; St. Vincent's Hospital, Toledo; Toledo Hospital, Toledo; Youngstown Hospital, Youngstown; St. Elizabeth's Hospital, Youngstown; St. Rita's Hospital, Lima.

Also there has been a rapid development in the hospital field of that phase of graduate education which provides special training in the specialties. At present there are 349 hospitals in the country, with a bed capacity of 218,495 and providing 2,069 residencies, which have been approved by the Council on Medical Education and Hospitals of the A. M. A. as adequate for training in the special branches of medicine or surgery.

Twenty-three Ohio hospitals are included in this list. They are:

Children's Hospital, Akron; City Hospital, Akron; Children's Hospital, Cincinnati; General Hospital, Cincinnati; Cincinnati Sanitarium, Cincinnati; Deaconess Hospital, Cincinnati; Good Samaritan Hospital, Cincinnati; Charity Hospital, Cleveland; Babies' and Children's Hospital, Cleveland; City Hospital, Cleveland; Cleveland State Hospital, Cleveland; Lakeside Hospital, Cleveland; Maternity Hospital, Cleveland; Mt. Sinai Hospital, Cleveland; St. Alexis Hospital, Cleveland; St. Ann's Maternity Hospital, Cleveland; St. Luke's Hospital, Cleveland; Columbus State Hospital, Columbus; Dayton State Hospital, Dayton; Massillon State Hospital, Massillon; Ohio State Sanatorium, Mt. Vernon; Toledo State Hospital, Toledo; Women's and Children's Hospital, Toledo.

STANDARDS FOR REGISTERED HOSPITALS

Your committee has cooperated with and assisted the Council on Medical Education and Hospitals in investigating the status of Ohio hospitals and it has furnished the A. M. A. Council with much information used in the rating of Ohio hospitals.

Any hospital seeking admission to the registry of the A. M. A. Council and its endorsement must subscribe to the following principles and meet the following conditions:

1. Must have a staff made up of one or more properly qualified physicians who shall be graduates of reputable medical schools; and all physicians treating patients in the hospital must be so qualified.

2. An able management which, depending on the size of the hospital, may be in the hands of a competent physician, an able superintendent, or a board of trustees.

3. A competent physician-pathologist, either on the staff or easily accessible, who should examine and keep a record of tissues removed at all operations conducted in the hospital.

4. Careful histories and records of all patients admitted to the hospital with which should be filed reports of any laboratory analyses, roentgen-ray findings or pathologic reports of any tissues examined.

5. One or more competent nurses, depending on the average number of its patients.

6. Regular staff conferences, at least monthly and preferably weekly, in all hospitals having staffs of three or more physicians.

7. Hospitals are institutions which should not be conducted for profit but for the purpose of securing better medical service for the community and they should always be conducted in accordance with the code of ethics of the American Medical Association.

DATA ON OHIO HOSPITALS

It is to the credit of Ohio that it is well supplied with institutions willing to comply with these principles and standards, there being 279 Ohio hospitals, sanatoriums and related institutions now registered by the A. M. A. Council and approved by it. The total bed capacity of these institutions is 47,411.

The following data and statistics on Ohio instituions which have been approved by the Council on Medical Education and Hospitals are of interest and are further evidence of the high standing of the state in the hospital field:

Ohio has 49 hospitals, with 7091 beds, owned and controlled by churches; 5, with 432 beds, controlled by fraternal orders; 2, with 31 beds, controlled by industrial concerns; 43, with 809 beds, controlled by individuals or partnerships; 104, with 7666 beds, independently controlled; 5, with 1602 beds, controlled by the federal government; 23, with 23,788 beds, controlled by the state; 23, with 2311 beds, controlled by counties, and 25, with 3681 beds, controlled by cities.

Dividing Ohio's 279 approved hospitals according to type of service, we find the state has 159 general hospitals, 27 nervous and mental, 16 tuberculosis, 13 maternity, 2 industrial, 6 convalescent and rest, 3 isolation, 4 children's, 10 eye, ear, nose and throat, 2 orthopedic, 31 institutional, and 6 unclassified.

Special services offered by Ohio's approved hospitals are as follows: 179 laboratories, 188 X-ray departments, 104 physical therapy departments, and 76 accredited schools of nursing.

Sixty-five of the 88 counties of the state, or 73.9 per cent of all the counties, have one or more approved hospitals, the precentage of the 3076 counties of the country having approved hospitals being 59.5.

COOPERATION IS ESSENTIAL

Even this general review of medical education and the hospital field is sufficient, in the opinion of your committee, to show the close relationship existing between the medical school, the hospital and the practicing medical profession.

The rapidly increasing interdependence of hospitals and physicians is especially noticeable. As the editor of *The Journal of the American Medical Association* has said:

"The greater the development of such institutions as have been described, the more extensive their use by the people, the more active must become the interest of the physician in their direction and control. It seems so simple to leave the economics, the construction, the administration of hospitals to lay boards and superintendents that far too many physicians are content simply to have the hospital as a work place

ready for them and their patients. Thus the attitude has grown among many philanthropists and hospital workers that the physician is the recipient of these facilities from the public and must therefore be under their direction. Nothing could be more fallacious. The doctors make the hospital. Without them it necessarily falls. Its merits are equivalent to their merits and cannot surpass them. This fact should be realized by lay directors, who should take their medical staffs into consultation on every matter affecting the welfare of the institution and be guided by them in every scientific problem."

The medical profession should consider it a duty to cooperate with and assist hospitals in solving their social and economic, as well as their scientific problems, many of which are similar in many respects to those which confront the medical profession in practice outside the hospitals. Some Ohio hospitals have been forced to close their doors because of financial difficulties. Others have been compelled to curtail services. Your committee does not intend to even suggest how hospitals, with their variety of community problems, should act to meet these serious economic questions. Numerous efforts now are underway for solutions for some of them.

However, we do urge the medical profession, collectively and individually, to consider the hospital's problems their problems and to be of whatever assistance they can to hospital executives in order that this valuable adjunct of medicine may be maintained on high scientific and sound economic planes.

Annual Report of the Special Committee on Periodic Health Examination

V. C. ROWLAND, Chairman ..... Cleveland
JONATHAN FORMAN ..... Columbus
BEATRICE T. HAGEN ..... Zanesville
R. R. HENDERSHOTT ..... Tiffin
C. I. STEPHEN ..... Ansonia
DON K. MARTIN, Secretary ..... Columbus

In 1861, Dr. Horace Benge Dobell, an English physician, scholar and teacher, published a book entitled, "Germs and Vestiges of Disease", in which the following comments were made, startling to his colleagues of that period, but significant when viewed in the light of our present understanding of the importance and value of both preventive and curative medicine as life-preserving and life-saving agencies:

"I am perfectly convinced, from my own observations and experience in practice, that patients, never think of consulting their doctors till these conditions of impaired general health have advanced far enough to have been developed into some form of disease; that thousands and thousands of people, believing themselves to be in health, are nevertheless undergoing these early, occult and evasive stages of defect in the physiological state; and that such persons may be considered to be in health, not only by themselves, but by anyone accustomed to associate with them, even though it be a physician, and that even if they submit to a medical examination as ordinarily conducted they may be declared to be in health.

"I wish then to propose as the only means by which to reach the evil and to obtain the good, that there should be instituted as a custom, a system of periodical examination, to which all persons should submit themselves, and to which they should submit their children * * * If such a plan as I have proposed were to be faithfully and conscientiously carried out by the present and rising generation of well-educated, studious medical men, I think no one can doubt, after a careful consideration of the subject, that immense benefit would be conferred upon the public."

Dr. Dobell is credited with having been the first to suggest in definite terms that a regular routine physical examination at the hands of the family physician would be a valuable protection against disease.

Many years have elapsed since the above was written. During that time, medicine has made phenomenal progress and achieved remarkable results. The period dating from the publication of Dr. Dobell's book to the present time has perhaps been the most colorful and productive era in the history of medicine.

One of the things which has made the period referred to so important, not only from the standpoint of the medical profession but from that of society as well, has been the development of the field of preventive medicine to a point where the practice of preventive medicine is generally regarded as more profitable, as well as more satisfying and productive of good results in the preservation of the health of individuals and also of the community, than curative medicine alone.

The field of preventive medicine is really enormous. Starting with the development of public health work on a community basis, through the control and prevention of contagious and infectious diseases by immunization and quarantine and the establishment of laws and regulations governing sanitation and hygiene, the preventive medicine which we know today includes not only these important activities, but functions dealing with the physiological and psychological as well as the organic health of the individual.

Out of that phase of preventive medicine which deals with a consideration of individual problems of disease and health, and endeavors to educate the public to utilize present-day medical knowledge, in controlling and retarding the onslaught of organic and chronic conditions, has evolved the periodic health examination movement.

In a recent address before an eastern medical society, Dr. Donald B. Armstrong, a vice president of the Metropolitan Life Insurance Company

in charge of health activities, made the following statement with reference to periodic health examinations.

"They are not of course, a panacea for all ills, nor will they detect or insure the prevention or cure of all ills. Yet the health examination is, potentially at least, the keystone of modern preventive medicine, and the nucleus around which the more important and personal hygiene activities are likely to be developed."

The importance of regular routine physical examinations by family physicians and the definite place which this movement has in modern preventive medicine were ably discussed and analyzed by our Chairman, Dr. Rowland, in an article "Personal Preventive Medicine", published in the February, 1932, issue of *The Ohio State Medical Journal*. Dr. Rowland's article prepared at our suggestion and published at our request, incorporated the ideas and suggestions of this committee on the subject of periodic health examinations.

As Dr. Armstrong has intimated, the health examination is not a panacea for all ills nor is it infallible in detecting hidden ailments. Its meritorious attributes have no doubt been overemphasized and exaggerated by some of its overenthusiastic supporters. Possibly, in some instances, it may arouse in the patient a sense of false security, without proper emphasis upon the importance of the rules of hygiene and temperate living. No doubt tactless discussion of disease probabilities in certain individuals excites fright, worry, hysteria and neurasthenia. The examiner should stress the possibilities of greater health and efficiency.

On the other hand, it appears evident that the justifiable criticisms which have been raised against some phases of the periodic health examination movement are many times outweighed by evidence concerning the value of the examination in the early discovery of diseases and defects in time for their cure, correction, or partial repair. We believe that the basic idea of routine physical examinations by family physicians is fundamentally sound and that much of the criticism which has been directed at the periodic health examination movement has for the most part been aimed at abuses which have grown out of efforts to popularize and exploit the movement.

One of the developments which has been criticized is the tendency on the part of some spirited supporters of the periodic health examination movement to leave the impression with the public that the periodic health examination is a definite assurance of increased longevity; that it is a guarantee against disease, and that it is positive evidence that physical disability does or does not exist. Considerable misunderstanding has been created through the promiscuous distribution of poorly prepared and inaccurate publicity and propaganda. Furthermore, there has been a tendency on the part of some groups and individuals to make the periodic health examination movement a publicity pawn for the promotion of highly specialized so-called public health activities which deal primarily with special and specific diseases and show little consideration for the general physical condition of the individual.

Another factor which has had anything but a stimulating effect on the periodic health examination movement is the misconception on the part of some that this phase of medical practice can be mechanized and conducted in clinics on a mass-treatment basis, with little or no regard for the individual's habits, mode of living, hereditary tendencies, social and economic environment, and other circumstances which in many cases are known only by the family physician. Close, personal relationship between the patients and physicians is just as essential in this phase of medical practice as in all others.

A third development which has had an evil and retarding effect on the whole periodic health examination movement is the entrance into this field of organizations, groups and individuals for the purpose of commercializing the idea. Obviously, this commercial exploitation has cheapened the service rendered in the minds of many individuals and obstructed its development to a considerable extent. The inferior service given by such commercial agencies on a cut-rate basis has been detrimental to the public health. Furthermore, the methods employed by these concerns, employing certain physicians on a salary basis to make the examination and submit their reports to a "central office" for interpretation and a recheck, has tended to undermine the confidence of a portion of the public in the ability of the local medical profession. Such tactics have disturbed the relationship between the public and local practitioners, and anything that disturbs this relationship is detrimental to the best interest of the public.

In spite of the problems which have arisen, some of which are purely academic, and in spite of some questionable methods employed in exploiting the periodic health examination movement, an enormous increase in the popularity of the service has taken place. The demand on the part of the public for routine physical examinations has grown rapidly. Numerous articles in magazines and newspapers, public discussions and addresses, the advertising of insurance companies and other business firms, the radio, the health conservation programs and activities of industrial plants, railroads, health and physical education activities in the schools and colleges, and programs conducted by various official and volunteer organizations and groups, all have aroused interest in preventive medicine generally and increased interest in periodic health examinations. The physical examination has become a fundamental and vital

part of preventive medicine. It is here to stay and will increase in importance.

This leads us to the question: How does the medical profession fit into the picture?

This Committee on Periodic Health Examination during the past year has been especially interested in this phase of the question. It has endeavored to study the problems involved in the light of their effect on the private medical practitioner. It has tried to visualize the future of the periodic health examination movement to determine, if possible, what its effect will be on private medical practice and what part the medical profession will, or should have, in the more extensive development of this service which is inevitable.

Despite the interest and cooperation of the profession generally in some phases of preventive medicine, we are of the opinion, however, that far too many physicians are apathetic and indifferent with regard to periodic health examinations. There is a definite inertia on this subject among some members of the medical profession as contrasted with the interest and receptiveness of the public. Some physicians belittle the need and value of this service. Others make a casual, perfunctory, inadequate and unsatisfactory examination when requested to do so by their patients. The first of these two groups can be excused to a certain extent, despite their failure to keep abreast of the times, on the ground that they are at least frank and honest relative to their stand on the question. The attitude of the second group can not be condoned under any circumstances.

Viewing the question in a general way from the standpoint of the medical profession, this committee feels that the need of interesting the profession itself concerning periodic health examination is much more important, especially at this time, than of stimulating the laity on this subject.

With this in mind, this committee believes that the activities of the State Association in this field, with this committee acting as its agent, should for the most part consist of a constructive, consecutive, and logically continuous program, conservative and educational in character, to stimulate interest among the physicians of Ohio in the periodic health examination movement; to emphasize to all the valuable service they can render their patients by including routine physical examinations as a part of their regular practice; to keep the profession fully informed of new developments in this field, and to stress the importance of using this comparatively new service as a means of extending their practice and enlarging their incomes.

Although the Committee on Periodic Health Examinations hopes to be able to accomplish considerable along the lines suggested by communicating from time to time to the membership through the secretaries of the various county medical societies and academies of medicine, and by articles in *The Journal*, the greater responsibility for developing this program and making it a success rests directly with the county societies and academies of medicine.

We strongly urge that each county society and academy of medicine form a committee, if it does not already have one, on preventive medicine, one of the functions of which would be to carry on a campaign of emphasis and reemphasis among the members of the society along the lines we have suggested. Furthermore, we recommend that each county society and academy devote at least one meeting, and several if practicable, during the coming year to the subject of preventive medicine as a part of private practice and including periodic health examinations.

It is suggested that two points which this committee believes highly important be stressed to the members:

First, that the ordinary routine physical examination should be simplified as much as possible. A mistake frequently made by periodic health examination enthusiasts is in insisting on an impractical, unnecessary and exhaustive examination, and that the forms used for recording the data disclosed by the examination be too elaborate. The average examination should be reasonable, careful and thorough. If there is any reason to suspect some defect not detected in such an examination, then the patient should be given more extensive examination, with the various laboratory tests that are indicated. Obviously, if the condition of the patient as revealed by the routine examination indicates specialized treatment, he should be advised of this and directed accordingly.

Second, no attempt should be made to standardize fees for periodic health examinations. Each examination should be as elaborate as the condition of the patient indicates. Special tests may or may not be necessary. Charging a standardized fee for this kind of service would in the majority of cases result in overcharging or undercharging, affecting the purse of the patient or the physician as the case may be. Standardization of fees generally implies that the knowledge and skill of the physician can be purchased in all instances at prevailing market prices, like ordinary commodities, regardless of the condition of the patient or of the amount of time and effort which the physician is required to give.

Any program of activity which a county medical society or academy of medicine should decide to undertake may include cooperation between the society and various local civic, welfare and health groups and organizations in the promotion of the periodic health examination movement. The advice and counsel of the profession should be given to such groups to guide them in their activities. Individual physicians when invited to do so, may with propriety, appear before civic groups, clubs, societies and public gatherings to discuss the question of health examinations and other subjects having to do with preventive and curative medicine. A number of county medical societies and academies have formed contacts of this char-

acter and have been of much assistance in promoting health programs among the laity.

However, your committee believes that the profession at this time should not take the lead in promoting general publicity on the subject of periodic health examinations or in sponsoring health examination campaigns. Such activities are being adequately taken care of by other groups whose motives and intentions are not likely to be misunderstood or misinterpreted. Of course, physicians can, and should, counsel their own patients on the value of a regular routine physical examination in their contact with them. As pointed out previously, the primary function of local medical groups should be to interest members of the profession in this phase of preventive medicine; to urge as many physicians as possible to include this service in their regular practice, and to create a desire on their part to acquire more knowledge on and develop greater skill in the details of the examination itself.

Most of the present-day educational campaigns among the laity emphasize the point that periodic health examinations are a part of regular medical practice and that the family physician is the keyman in rendering this service. This is as it should be. There is no logical reason why such a type of practice should be made a specialty. Practically all general practitioners are adequately prepared to make a thorough and complete routine physical examination if they have the desire and willingness to do so. The family physician with his intimate knowledge of the patient and his history is more likely to make an examination of greater value to the patient than the physician seeing the patient for the first time.

As pointed out in the February article previously referred to, "a system of periodic health examinations provides a new opportunity to the people at large to reestablish their connections with a family medical adviser and mentor in matters of health". And, to quote Dr. Armstrong again "the periodic health examination is a vital anchorage for the current private practice of medicine".

The vital question which confronts us is: Will the medical profession hasten to adjust itself to this new trend, this new movement in preventive medicine and will it prepare itself to meet the increasing demands for this service? We believe it will if encouraged and stimulated by constructive but conservative activities as suggested in this report.

Annual Report of the Committee on Auditing and Appropriations

(Including Jointly the Report of the Treasurer and the Annual Audit)

S. J. GOODMAN, Chairman ..... Columbus
C. L. CUMMER ..... Cleveland
E. M. HUSTON ..... Dayton
DON K. MARTIN, Secretary ..... Columbus

Medical organization in Ohio is at present passing through one of the most vital periods in its history of almost nine decades of service to the medical profession and the public of this state.

The numerous problems confronting the profession have become more complicated, more complex, and more serious during the past year on account of the uncertainty of business conditions and the general spirit of unrest which has permeated society.

Because many of these problems promise to become even more acute during the coming year, it is imperative that our organization machinery be maintained at the greatest possible efficiency so that the State Association may render even greater service and stronger protection to its members, individually and collectively, and promote those activities which will better conserve and protect the health of the public.

To function properly and effectively, any organized group must have adequate funds with which to carry on necessary activities and promote those things which will accomplish its aims and objectives.

On the other hand, it is equally important that these funds be handled in a careful, conservative and business-like manner; budgeted judiciously; expended economically, and conserved where possible in order that reserves may be accumulated for the proverbial "rainy day".

To the Committee on Auditing and Appropriations has been delegated by the Council, under our Constitution, the responsibility of supervising the financial affairs of the State Association and *The Journal* in such a way that the sound financial condition of both will be maintained and that the principles above enumerated are observed.

As customary, this committee has employed a certified public accountant to audit the records of all financial transactions of the State Association and *The Journal* for the calendar and fiscal year, closing December 31, 1931. The accountant's report, appended to the report of this committee, reveals not only the sound financial condition of the State Association and *The Journal*, but also evidences the efficiency of the system utilized by the Committee on Auditing and Appropriations in supervising and regulating the financial affairs of

the Association and the thorough and effective management of the headquarters office.

Realizing that current unsettled business conditions have made it necessary for all individuals, groups and organizations, to carefully scrutinize their financial dealings, this committee, during the past year, has been if possible even more diligent than ever in discharging the responsibilities delegated to it. All bills were carefully examined and re-examined before approved for payment. Of course, no bills were paid until vouchers were certified to and approved by the committee. Furthermore, no expenses were incurred unless authorized in advance, through proper budgeting by the Council.

Because of the systematic manner in which the financial affairs of the State Association have been supervised and the organization activities of the Association planned and regulated, all the expenditures during 1931 were kept within the budgetary allowances and authorizations made by the Council at the beginning of the year. This system of maintaining an even balance between anticipated revenues and future activities of the State Association has been of primary importance in conserving the financial resources of the Association without impairing in any way its service to the membership.

The State Association closed the year 1931 with an accumulated balance which has been added to the reserve funds of the Association now invested in government bonds and securities. During the year, the State Association added to its income by investing in short-time securities and certificates of deposit, funds not needed immediately for current expenses and leaving them there to draw interest until it was necessary to transfer them to the checking account. Due to a slight decrease in advertising revenue from *The Journal*, which made it necessary to use more State Association money in the publication of *The Journal*, and the fact that the commercial exhibits at the last annual meeting in Toledo produced little or no profit, the accumulated balance at the end of 1931 was somewhat smaller than that of the preceding year.

The Committee on Auditing and Appropriations realizes that it may be confronted with new and unusual difficulties and problems during 1932 because of the economic situation, and that extreme care must be exercised in handling the financial affairs of the State Association during the forthcoming twelve months.

As pointed out at the beginning of this report, the trend of the time makes it relatively more vital and important that medical organization machinery be maintained at a higher degree of efficiency than ever before. We can not afford to adopt a penny-wise, pound-foolish attitude which ultimately would cripple the service of the State Association to the membership. On the other hand, we must economize wisely and reduce expenditures for unnecessary, although possibly desirable activities, so that it will not become necessary except in an extreme emergency to use any of our reserve balance for current expenses.

In an effort to strike a practical and reasonable medium, your committee shortly before the beginning of the current year, submitted to the Council a proposed budget for 1932 which was somewhat smaller than the budget under which the State Association operated during 1931. After careful consideration of the recommendations of the committee, the Council approved the suggested budget at its meeting on December 13, 1931 (January, 1932, issue of *The Journal*). As pointed out by the committee at that time and published as a part of the minutes of the Council meeting, cuts in the budget were made in routine expenses; where it was believed they would be felt the least, and where they would not handicap the State Association in performing functions of service and benefit to the membership generally.

The Committee on Auditing and Appropriations believes that the splendid spirit of cooperation which exists between the State Association officers, committeemen, headquarters personnel, and the membership at large will make it possible for the State Association to carry on with its customary high degree of efficiency and that the effect of this reduction of budgetary authorizations for operating expenses will be minimized.

The above mentioned audit of the finances of the State Association and *The Journal* by certified public accountants for the calendar and fiscal year 1931 follows:

Accountant's Report for the Ohio State Medical Association for the Year 1931

Chairman Auditing Committee,
Ohio State Medical Association,
Columbus, Ohio.
Dear Sir:

In accordance with your instructions, we have audited the books of the Ohio State Medical Association, for the year ended December 31, 1931, and submit herewith our report, including as a part thereof the following schedules:

SCHEDULE A: Statement of Cash Receipts and Disbursements for the year ended December 31, 1931.

SCHEDULE B: Statement of Cash Reconciliation at December 31, 1931.

AUDIT—All recorded cash was traced to the depository. All disbursements were verified by examination of cancelled checks supported by vouchers, properly approved. Cash on deposit at December 31, 1931, as shown by a certificate from the bank, was reconciled with the balance as shown by the books at that date.

Certificate of deposit and United States Gold and Treasury Bonds were verified by actual inspection.

CERTIFICATE—We therefore certify that, in our opinion, the statement herein contained correctly states the Cash Receipts and Disburse-

ments of the Ohio State Medical Association for the year ended December 31, 1931.

Respectfully submitted,
KELLER, KIRSCHNER & MARTIN,
Certified Public Accountants.

SCHEDULE A—STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS FOR THE YEAR ENDED DECEMBER 31, 1931.

Cash on Hand and on Deposit at January 1, 1931		$ 581.27
Certificate of Deposit		35,000.00
United States Gold Bonds		25,000.00
Total Cash January 1, 1931		$60,581.27
Receipts		
Membership Dues 1931	$27,321.00	
Annual Meeting	2,155.00	
Interest	1,862.96	
Total Receipts		31,338.96
Total to be accounted for		$91,920.23
Disbursements		
Ohio State Medical Journal	$ 7,000.00	
Executive Secretary	6,600.00	
Executive Secretary—Expense	502.79	
Assistant Executive Secretary	3,850.00	
Assistant Executive Sec'y—Expense	105.15	
President's Expense	214.51	
Treasurer's Salary	300.00	
Council Expense	490.44	
Annual Meeting	1,970.19	
Auditing	100.00	
Committee on Public Policy	1,318.74	
Medical Defense	2,412.15	
Miscellaneous Commitee Expense	44.71	
Stationery and Supplies	354.47	
Postage and Telegraph	519.74	
Additional Salaries	1,130.00	
General Counsel	2,100.00	
Total Disbursements		29,012.89
Cash on Hand and on Deposit December 31, 1931		62,907.34
Total Balance as shown by the books at December 31, 1931		$91,920.23

SCHEDULE B—STATEMENT OF CASH RECONCILIATION AT DECEMBER 31, 1931.

The Huntington National Bank

Balance as shown by Bank Statement—December 31, 1931		$ 3,058.64
Less Outstanding Checks		151.30
Balance as shown by books at December 31, 1931		$ 2,907.34
United States Gold Bonds	$25,000.00	
United States Treasury Bonds	30,000.00	
Certificate of Deposit: No. 1326 First-Citizens' Trust Co.—(Ohio National Bank)	5,000.00	
Total Bonds and Certificates of Deposit		60,000.00
Total Balance as shown by the books at December 31, 1931		$62,907.34

Accountant's Report for the Ohio State Medical Journal for the Year 1931

To the Committee on Auditing of the
Ohio State Medical Journal,
Columbus, Ohio.
Gentlemen:

In accordance with your instructions, we have audited the books of the Ohio State Medical Journal, for the year ended December 31, 1931, and submit herewith our report, including as a part thereof the following described Schedules:

SCHEDULE A: Balance Sheet at December 31, 1931.

SCHEDULE B: Statement of Revenue and Expense for the year ended December 31, 1931.

These Schedules are supported by exhibits showing details of various accounts incorporated therein.

Financial Condition

The financial condition of the Ohio State Medical Journal at December 31, 1931, (as shown in detail in Schedule A) was as follows:

Cash on Hand and on Deposit	$ 1,120.39
Accounts Receivable	1,073.06
Total Current Assets	$ 2,193.45
Less Current Liabilities	63.50
Net Current Assets	$ 2,129.95
Furniture and Fixtures	1,840.39
Total Net Assets	$ 3,970.34
The above is represented by:	
Surplus	$ 3,970.34

AUDIT—All recorded cash was traced to the depository. The disbursements were verified by examination of cancelled checks, supported by properly approved invoices. Cash on deposit at December 31, 1931, as shown by a certificate from the bank, was reconciled with the balance as shown by the books at that date. Petty Cash vouchers were checked and the amount on hand was verified by actual count as of a present date during the audit.

CERTIFICATE—We therefore certify that, in our opinion, the statements herein contained correctly state the financial condition of the Ohio State Medical Journal at December 31, 1931, and the Revenue and Expense for the year ended on that date.

Respectfully submitted,
KELLER, KIRSCHNER & MARTIN,
Certified Public Accountants.

Schedule A

ASSETS

Current Assets		
Cash—The Ohio National Bank	$ 1,110.39	
Cash—Petty	10.00	
Total Cash (Exhibit No. 1)		$ 1,120.39
Accounts Receivable (Exhibit No. 2)		1,075.06
Total Current Assets		$ 2,193.45
Property Assets		
Furniture and Fixtures		1,840.39
Total Assets		$ 4,033.84

LIABILITIES

Current Liabilities		
Subscriptions Prepaid		$ 63.50
SURPLUS		
Surplus at December 31, 1930	$ 3,944.51	
Revenue in excess of Expense for the year ended December 31, 1931	25.83	
Surplus at December 31, 1931		3,970.34
Total Liabilities and Surplus		$ 4,033.84

STATEMENT OF REVENUE AND EXPENSE FOR THE YEAR ENDED DECEMBER 31, 1931.
SCHEDULE B

Revenue			
Advertising		$12,750.56	
Less—Commissions	$894.36		
Cash Discount	388.82	1,283.18	$11,467.38
Circulation			7,000.00
Miscellaneous			99.60

Bad Debts Collected		55.00	
Total Reenuve			$18,621.98
Expense			
Journal Printing	$11,260.36		
Office Salaries	3,812.75		
Rent	1,500.00		
Journal Postage	527.28		
Telephone and Telegraph	260.41		
Depreciation	196.15		
Bad Debts	248.75		
Journal Envelopes	234.25		
Office Supplies and Expense	135.45		
Stencils and Mimeograph Supplies	121.62		
Water, Ice and Towel Service	99.85		
News Clipping Service	78.00		
Dues and Subscriptions	60.50		
Repairs and Cleaning	15.65		
Halftones and Etchings	3.75		
Express and Delivery Service	8.83		
Miscellaneous Expense		32.55	
Total Expense			18,596.15
Revenue in Excess of Expense for the year ended December 31, 1931			$ 25.83

STATEMENT OF CASH RECONCILIATION AT DECEMBER 31, 1931.

The Ohio National Bank

Balance as shown by Bank Statement at December 31, 1931	$ 1,133.95
Less Outstanding Checks	23.56
Balance as shown by books at December 31, 1931	$ 1,110.39
Petty Cash	10.00
Total Cash	$ 1,120.39

Annual Report of The Committe on Mental Hygiene

E. J. EMERICK, Chairman ..... Columbus
O. O. FORDYCE ..... Toledo
L. J. KARNOSH ..... Cleveland
WILLIAM H. PRITCHARD ..... Columbus
T. A. RATLIFF ..... Cincinnati

"We seem likely to go forward as a people for many centuries so far as the physical possibilities are concerned. The great question as we look ahead is: 'What kind of people are we to be from the standpoint of the mind and of behavior?'

"Democracy demands at least a majority of self-maintaining competent citizens with orderly, cooperative habits and with balanced, temperate minds. Disaster awaits any people with too high a percentage of the insane, mentally defective or the emotionally unstable. Trouble stands at the door of any people who are not partially immune to sophistry. In sanity lies safety. Certainly we do not want to think of a period in which a considerable minority of our population is either living in institutions or entering or leaving them.

"That a nation's strength depends on its mental health is obvious. That our nation can settle down to study its present mental state is evident. That we are going along with a lot of absurd and foolish methods of handling our mental cases and our criminals is obvious. So far as insanity is concerned, the public is largely still in the dark ages, and the medical profession is in the twilight zone. The mental health of a nation is its greatest asset."

—Dr. Ray Lyman Wilbur.

In an address before the American Statistical Association, Dr. Horatio M. Pollack of the New York State Department of Mental Hygiene estimated the annual economic loss in the United States because of mental ailments at approximately $742,000,000, about three-fourths of which represents the average annual earnings of individuals treated as first admissions to mental hygiene institutions and the remainder the cost of hospital maintenance and services to patients.

The discussions on mental hygiene problems which have been held at the last two sessions of the Annual Congress on Medical Education, Medical Licensure and Hospitals, have produced a vast array of scientific data on mental disorders and an endless amount of valuable information regarding social, economic and administrative phases of the question.

Another example of the renewed interest which medical organization is taking in this question is the survey now being conducted by the Council on Medical Education and Hospitals of the A.M.A. of all hospitals caring for mental patients, in order to obtain a more accurate knowledge of the situation and the need for further developments. In the last preliminary report of the Council on its survey, made in February, it was pointed out that questionaires had been sent to 561 institutions for nervous and mental patients; that 416 of these questionaires have been returned, and that visits have been made to 353 institutions by investigators for the Council.

Some interesting data on existing facilities for caring for and treating nervous and mental patients is found in the report, for example:

"Of the government-owned group, the Veterans' Administration hospitals are on the whole comparatively new and well equipped, have relatively large medical staffs, and apparently give the individual patient good custodial and therapeutic care. Among the county and city institutions, the great majority of those visited were found to be custodial in nature, without any aspirations to the rank of hospitals.

"In state hospitals, which are nearly three times as numerous as all federal, county and city institutions, personal contact with administrative heads revealed that overcrowding was almost universal. In several places, it had been carried to a most deplorable extreme. Recreation rooms, living rooms and dining rooms had been made into dormitories. Beds had been placed on porches, in hallways, in attics and in basements. The lack of room was in some instances such as to rule out almost all classification on a basis of diagnosis or therapy, the only workable classification being on the basis of temperament; and without proper classification adequate care is impossible.

"In several of these state hospitals there were no hospital units, the word hospital being applicable to them only in the broadest sense of the term. Others had no separate receiving units. Some lacked the equipment for giving patients proper diagnostic or therapeutic care. The personnel in many was admittedly inadequate, attendants being both too few and too incapable, and the medical staff being greatly undermanned. In the presence of such conditions no special

knowledge or training was required for their discovery; indeed, if it had been required, many of the superintendents made it unnecessary by themselves calling the visitor's special attention to the conditions; the superintendents desired that such conditions be reported, in the hope that such a report might lead to their improvement.

"Private institutions fall easily into two classes: the sanatoriums and the rest homes (sanatoriums being interpreted as places for therapeutic care while rest homes are merely custodial). Nearly all sanatoriums were found clean, orderly, and apparently well conducted. They return a comparatively large percentage of their patients to active civil life, and they apparently merit the respect and support of the medical profession. While many rest homes meet a real need in a satisfactory way, several others have no adequate medical supervision and their value as medical institutions is nebulous."

One report on a recent survey of psychiatric clinics points out that while a decade ago such clinics were comparatively rare, today there are approximately 700 scattered throughout 34 states. Although the majority of these mental health centers are engaged in handling juvenile problems, the report reveals that some 36,000 adults appeared at them during the past year.

"This is equal to about half the number of patients admitted to mental hospitals in the United States each year," it is stated, "a hopeful sign of progress in community management and control of what is undoubtedly the country's greatest public health problem at the present time. It is also an indication of the growing public interest in prevention. People are learning to consult the doctor about their mental ills just as they do for any other sickness."

The extensive development of psychiatric and mental hygiene activities throughout the country makes it imperative that the medical profession take an even greater interest in this public health problem than it has shown in the past. Well-informed authorities point out that this is essentially a medical problem and must be handled by the medical profession to a large degree.

A program for the development of psychiatric personnel to meet the needs of expanding mental hygiene activities has been launched by the National Committee for Mental Hygiene. The main objectives of the program are: to work out plans for recruiting and training psychiatric and mental hygiene personnel; to secure more qualified candidates for such work; to appraise and to assist in the development and improvement of existing educational facilities for the training of psychiatrists; to study present programs being followed in teaching undergraduates and graduates in medical schools; to administer fellowships, and to assist in placing trained personnel in university, hospital and community mental hygiene work. It is the hope of the committee to stimulate psychiatric training in medical schools and to attract medical students to devote greater consideration to this problem.

Your committee believes that this program probably will tend to stimulate specialization in this branch of medicine. There is a definite need for a greater number of specialists in psychiatry. On the other hand, equal emphasis should be placed on programs for arousing interest among the thousands of general practitioners of the country—the family doctors who, it has been conceded, are in the first line of defense against mental breakdowns, and who, through their intimate, personal contacts with their patients, can do much to prevent mental and emotional disturbances or take proper steps to control mental cases before they have reached the critical stage.

OHIO'S PROBLEMS

Despite the existence of conditions which have been termed "deplorable" by authorities who have made extensive mental hygiene studies in Ohio, there are indications that the people of the state are beginning to realize that this is a question of major importance.

Evidence of this is found in the extensive development of psychiatric clinics in connection with courts; in the interest which has been taken in improving social and economic conditions contributing to mental and emotional disurbances; in the concerted effort being made by groups and agencies to get mental cases into the hands of competent physicians in time to prevent, if possible, serious mental breakdowns; in the growing belief among large groups of society that preventive medicine applies to mental as well as physical disease, and in the greater study being given to the subject by physicians, individually and collectively.

Although some have pointed to the defeat last fall of the proposed state Welfare Bond Issue for $7,500,000 as an indication that public sentiment in Ohio has not been crystalized, it is probable that the serious economic situation was largely responsible for the defeat of that proposal, and that the adverse vote was not indicative that the public is unwilling, when conditions permit, to meet the problem facing it.

Perhaps the most serious mental hygiene problem which the state faces at the present time is that of providing adequate space and more extensive therapy facilities for thousands of unfortunates who are in need of institutional care.

Every state mental hygiene hospital in Ohio is seriously overcrowded. On December 31, 1931, the actual population of the Ohio state hospitals for the insane was 16,073, an increase of 1,027 over 1929 and an increase of 371 over 1930. The population of the three institutions for feebleminded and the State Hospital for Epileptics on December 31, 1931, was 6,917, an increase of 528 over 1929 and an increase of 293 over 1930.

The following tables of figures obtained from the State Department of Public Welfare show the

population of these institutions for 1929, 1930 and 1931:

	Dec. 31, 1929	Dec. 31, 1930	Dec. 31, 1931
Athens State Hospital	1,358	1,462	1,461
Cleveland State Hospital	2,284	2,323	2,321
Columbus State Hospital	2,405	2,476	2,570
Dayton State Hospital	1,314	1,378	1,446
Lima State Hosiptal	1,020	1,044	1,053
Longview State Hospital	1,908	2,108	2,230
Massillon State Hospital	2,633	2,712	2,706
Toledo State Hospital	2,124	2,209	2,286
Total	15,046	15,712	16,073
Inst. for Feeble-Minded, Columbus	2,013	2,116	2,055
Inst. for Feeble-Minded, Orient	2,429	2,478	2,453
In. for Feeble-Minded, Apple Creek			408
Ohio Hospital for Epileptics	1,947	2,030	2,001
Total	6,389	6,624	6,917

As pointed out by officials of the State Department of Public Welfare, the increase in the population of the hospitals for the insane has been made possible chiefly through the overcrowding of these institutions. Furthermore, the increase in population does not begin to indicate the increased need for institutional facilities since several of the larger hospitals have been forced to restrict admissions, taking only acute cases in need of immediate care. Consequently, hundreds of committed cases are at present being cared for in their homes and in county and city hospitals. Also, there has been a reluctance on the part of the courts in many communities to commit persons in need of institutional care due to the overcrowded conditions existing at all the institutions.

While the increase in the population of the institutions for the feeble-minded and epileptics was made possible to a large degree by the opening of the new institution at Apple Creek, Wayne County, this institution is now filled to capacity and no funds are now available for its expansion.

The serious housing condition confronting the Department of Public Welfare has had a deterrent effect on the work of the new Bureau of Examination and Classification of Prisoners. Although that bureau has recommended the transfer of many psychopathic and defective types from penal institutions to mental hygiene hospitals, little along this line has been accomplished due to the crowded conditions at the latter institutions.

Two factors stand out in an analysis of present conditions in Ohio:

First, there is a serious need for more housing facilities for the state's insane and mentally defective;

Second, as long as present overcrowded conditions exist, medical activities at all institutions will be handicapped and hampered.

The question of how much the institutional facilities of the state should be expanded to meet present-day needs is difficult to answer, since there is no way to accurately check the number of mentally ill and mentally defective in actual need of hospitalization.

Some authorities have estimated that Ohio should be caring for at least 250 persons per 100,000 population in its hospitals for the insane, instead of 224 per 100,000 as at present. This would mean another 2,000 persons who should be committed or re-committed to state hospitals. Furthermore, it is shown that the present state hosiptals for the insane are over-populated by at least 2,000 persons. So, conservatively speaking, these authorities estimate that the capacity of the state hospitals for the insane should be increased so as to care for at least 4,000 more individuals.

These same authorities believe that there is undoubtedly need for a total capacity at the institutions for the feeble-minded of at least 10,000. Present facilities only provide, even with serious over-crowding, for approximately 4,700. Little information is available as to the number of persons who should be hospitalized at the State Hospital for Epileptics, but it has been conservatively estimated that space should be provided for the housing of at least 2,000 more such patients.

A study made last fall by the State Department of Public Welfare showed that an expenditure of approximately $6,200,000 for expansion of existing mental hygiene institutions would provide quarters for a total of 3,185 additional patients, 1,860 in the hospitals for the insane, 1,200 in the institutions for the feeble-minded and 125 at the Hospital for Epileptics.

CONCLUSIONS

Your committee believes that the foregoing brief resume of some of the important problems in the field of mental hygiene, especially those confronting our own state, indicates quite clearly that these problems are inter-related to such a degree that the solution of one depends largely on what steps are taken to meet the others.

In the final analysis, it appears as if, for the present at least, the greatest emphasis should be placed on a well-planned institutional building program which will provide sufficient facilities for adequately quartering and treating those already in institutions and those who should be committed.

It is obvious that those in need of institutional care cannot receive it if there is no room in our institutions for them and if housing conditions are such that the highest degree of scientific care and treatment is impossible. Furthermore, it stands to reason that programs designed to detect those in need of institutional care or to segregate those who are a potential menace to society will be but lost motion as long as facilities for separating such cases from bad social environments or from society generally are unprovided.

Your committee is of the opinion that present conditions can be alleviated considerably through proper preventive measures, in which the medical profession must play a major role. Much progress along this line has been registered in recent years. However, as Dr. Wilbur has well pointed out, so

far as insanity is concerned the medical profession is in the "twilight zone", at least in as far as the sociologic phases are concerned.

The medical profession should, and is expected to, take an active and leading part in these undertakings. There is reason to believe that cooperative activity on the part of the medical profession and the public, accompanied by group initiative in dealing with the medical and social phases of this problem, will eventually lead to marked successes in our efforts to preserve the mental health of the citizenry, the same as similar activities have practically eliminated other conditions which were once a menace to the health of society.

Annual Report of the Committee on Military Affairs

HARRY D. JACKSON, Chairman ..... Circleville
DAVID H. MOORE ..... Urbana
LOUIS FEID, JR. ..... Cincinnati
DON K. MARTIN, Secretary ..... Columbus

Disturbing developments and events of the past year in international affairs including the more recent clash of armed forces in the Far East, have had a retarding effect on movements to bring about world-wide disarmament.

Despite the seemingly fervent desire on the part of most nations for world peace, the events of the past few months have had a tendency to arouse interest and attention in military prepardness.

Instinctively, with the apparent collapse of auspicious movements for the outlawry of war and for the peaceful settlement of international disputes, the nations of the world are studying present international conditions in the light of their possible effect in precipitating another conflict of serious proportions.

Military assets and needs are being carefully analyzed and not since the close of the World War has there been such a keen official interest in questions of military prepardness and national defense.

These are the facts as your committee sees them and they should serve as the background for this report which is not submitted for the purpose of promoting or stimulating a militaristic spirit among those who read it but for the purpose of outlining the part which the medical profession can and should take in activities along the lines of establishing an adequate defense for meeting national emergencies as they arise.

At the close of the World War when the military authorities of the United States had an opportunity to analyze the part which this country took in that conflict, they were unanimous in their opinions that our basic defense in time of war is in our citizen army, inasmuch as the Regular Army and National Guard are not strong enough to constitute anything but the first line of defense against the attack of a powerful enemy.

This view has gained strength during the intervening years until today we find a considerable portion of the energy and activity of the War Department directed toward the maintenance and development of an Organized Reserve, composed of persons engaged in civilian pursuits but who could be prepared, promptly, to become vital units in an effective fighting machine in time of war.

For a number of years the Ohio State Medical Association has had a Committee on Military Affairs, organized originally to serve as a contact unit between the military branches of the government and the medical profession of Ohio.

Although the committee has maintained a close contact with all the military departments of the government, it has been especially interested in the activities of the Medical Department of the Organized Reserve Corps and the Ohio National Guard, and has assisted in obtaining enrollments from the medical profession of Ohio in one or the other of these two branches of the service.

As demonstrated during the World War, a well-organized, well-equipped and well-trained medical and sanitary unit is indispensable to any army and has much to do with keeping the combat units effective. Naturally, the medical and sanitary units, to be efficient, must be officered by well-trained and competent men. Shortly before the end of the World War, the number of officers of the Medical Department of the United States Army alone totaled 40,453, indicating the importance and comparative strength of this particular branch of the service.

In case of another national emergency, a large proportion of the officers needed to command the medical and sanitary departments of the army must be taken from the ranks of the Organized Medical Reserve Corps, so the necessity of keeping this reserve force recruited to its fullest strength and of enrolling in it large numbers of competent and capable physicians, dentists, veterinarians, etc., is quite apparent.

During the past few months, this committee has made an investigation of the progress which has been made in Ohio in obtaining personnel for the Medical Department of the Organized Officers Reserve Corps, which includes medical, dental, veterinary, sanitary and medical administrative branches of the service.

Under the present scheme of mobilization as set forth by the War Department in its recent General Mobilization Plan, 27 Medical Department Reserve Units, located in Ohio, are listed for mobilization on M-Day, or day of mobilization. This number does not include the 12 Medical Department units of the Ohio National Guard and several Reserve Division Medical Units.

Mobilization of these units on M-Day would mean the calling into active service, at once, of approximately 1318 medical officers, practically all of whom are residents of Ohio. These units are distributed in the state as follows: Cleveland, 12 units; Columbus, 6 units; Cincinnati, 6 units; Dayton, 3 units. Not all the personnel assigned to the units is drawn from the city in which the unit is located, but as far as practicable the personnel in the immediate vicinity of the unit is assigned to it, in order that closer contact may be established between the unit commanders and the personnel.

Under this system of mobilization, provision is made for 11 general hospitals, three evacuation hospitals and four station hospitals. It also provides for one hospital train, a medical supply depot, two medical regiments, two surgical hospitals, a hospital center, a medical laboratory, aviation and an auxiliary surgical group.

Procurement of eligible medical personnel in Ohio in the Officers Reserve Corps has been carried on during the past year as in other years, with special emphasis being placed on contact with graduates of the medical schools of the state.

The following figures furnished this committee by Colonel O. G. Brown, Fifth Corps Area Surgeon, Fort Hayes, Columbus, headquarters for the area which includes Ohio, Indiana, Kentucky and West Virginia, show the distribution of Ohioans enrolled in the medical units and groups of the Officers Reserve Corps at the present time:

RESERVE OFFICERS OF OHIO

Active, Corps Area Assignment Group
(Under Corps Area Commander)

Branch	Col.	Lt. Col.	Major	Capt.	1st Lt.	2nd Lt.	Total
Medical	14	51	66	52	326	0	509
Dental	0	2	20	24	263	0	309
Sanitary	0	0	5	3	6	45	59
Med. Admin.	0	0	0	7	16	49	72
Veterinary	0	0	1	6	4	4	15
Totals	14	53	92	92	615	98	964

Inactive, Corps Area Assignment Group
(Under Corps Area Commander)

Medical	0	3	13	33	93	0	142
Dental	0	0	3	7	47	0	57
Sanitary	0	0	1	4	1	8	14
Med. Admin.	0	0	0	0	3	12	15
Veterinary	0	0	0	0	0	0	0
Totals	0	3	17	44	144	20	228

Active, Arm and Service Assignment Group
(Under Chief of Branch)

Medical	1	1	3	4	11	0	20
Dental	0	2	0	2	2	0	6
Veterinary	1	0	0	0	1	1	3
Med. Admin.	0	0	0	4	1	0	5
Sanitary	0	0	5	3	0	0	8
Totals	2	3	8	13	15	1	42

Inactive, Arms and Service Assignment Group
(Under Chief of Branch)

Branch	Col.	Lt. Col.	Major	Capt.	1st Lt.	2nd Lt.	Total
Medical	1	0	2	3	3	0	9
Dental	0	0	0	0	1	0	1
Veterinary	0	0	1	2	1	0	4
Med. Admin.	0	0	0	0	2	0	2
Sanitary	0	0	1	1	0	1	3
Totals	1	0	4	6	7	1	19

NATIONAL GUARD
(Dual Capacity

Medical	1	2	7	26	5	0	41
Dental	0	0	1	4	5	0	10
Veterinary	0	0	1	4	1	1	7
Med. Admin.	0	0	0	6	1	0	7
Sanitary	0	0	0	0	0	0	0
Totals	1	2	9	40	12	1	65

NEW APPOINTMENTS IN 1931

Medical	Dental	Veterinary	Med Admin.	Sanitary	Total
153	61	22	24	1	261

PROMOTIONS IN 1931

Medical	Dental	Veterinary	Med Admin.	Sanitary	Total
38	15	3	7	2	65

A comparison of the tables for this year with those of a year ago shows an appreciable gain in Medical Department Reserve Officers in Ohio, the total enrollment last year being 1204, compared to 1318 at the present time. However, the procurement quota for the Fifth Corps Area has not been attained and there still are vacancies in every branch of the department.

New Army regulations governing the Officers Reserve Corps became effective July 1, 1931. A number of important changes relative to reappointment and promotion were made which, it is hoped, will have the effect of saving many valuable medical reserve officers to the active list and make it possible for many officers now on the inactive list to become active.

For the information of members of the State Association who may be interested in enrolling in the Medical Department of the Organized Officers Reserve Corps, following are some of the essential points in the new army regulations governing the Officers Reserve Corps. Full details may be obtained from Colonel Brown at Fort Hayes:

GENERAL

Authorized Sections—Among the 19 authorized sections of the Officers Reserve Corps is the Medical Department Reserve, consisting of the Medical Corps, Medical Administrative Corps, Dental Corps, Veterinary Corps and Sanitary Corps (sanitary engineers, hospital architects, public health technicians, nutrition experts, psychologists, chemists, etc.)

In the medical and dental sections, the authorized grades in which appointment may be made are first lieutenant to colonel, inclusive; in the medical administrative section, second lieutenant to captain, inclusive, and in the veterinary and sanitary sections, second lieutenant to colonel, inclusive.

APPOINTMENT

Requirements—In time of peace, a reserve officer must at the time of his appointment be a citizen of the United States or of the Philippine Islands, between the ages of 21

and 60 years. However, initial appointments in time of peace in the lowest grade of the Medical Department, Officers Reserve Corps, will be restricted to applicants who do not exceed 35 years of age, except those who served as officers of the army between April 6, 1917, and June 30, 1919.

Applicants for the medical, dental and veterinary sections must possess an appropriate professional degree from an acceptable professional school; be licensed to practice in a state, territory or the District of Columbia; and be engaged in the ethical practice of the appropriate profession. Possession of a license to practice is waived for graduating Reserve Officers Training Corps applicants so that they may receive their commission at the same time they receive their professional degree. Those who have successfully passed the entire examination of the National Board of Medical Examiners are not required to possess a license to practice.

Length of appointment—Appointments in every case will be for a period of five years, but an appointment in force at the outbreak of war or made in time of war, will continue in force until six months after the termination of the war, should the five-year period covered by the appointment terminate prior to that time.

Applications and examinations—Applications for appointment must he accompanied by a report of physical examination by a medical officer of the Regular Army, Officers Reserve Corps, National Guard, Public Health Service, or a reputable civilian physician approved by the corps area commander.

An examination will be held as soon as possible after the application has been approved by the corps area commander at stations or places as near as practicable to the place of residence of the applicant.

The examination is conducted by a board of officers. In determining the fitness of the applicant for appointment, the board will investigate the moral character, professional standing and general adaptability for the service. The report of the board must also take into consideration the physical examination given the applicant. In determining professional standing and general adaptability, the board may give a written examination or it may accept in lieu thereof satisfactory evidence of the applicant's fitness by reason of previous military service or by reason of knowledge acquired in civilian occupation.

Former officers who held commissions in the army between April 6, 1917, and June 30, 1919, are eligible for consideration for appointment in any grade not above the highest previously held by them but they cannot be appointed to a grade above the lowest in any corps unless a vacancy exists under the procurement objective.

REAPPOINTMENT

By modifying somewhat the rigid requirements for reappointment, the War Department has saved many eligible men to the Officers Reserve Corps.

Under Section 28 of the new regulations provision is made whereby an officer may qualify for reappointment by reason of his civil occupation. This section reads as follows:

"Each chief of arm or service and each corps area commander is authorized to recommend any reserve officer under his assignment jurisdiction who has not qualified for reappointment as prescribed in paragraph 26 a or 27 a for reappointment with eligibility for assignment, active duty, and promotion, provided his work in civil life is similar to and fits him for the work he would be called upon to perform in the event of war. The recommendation will be forwarded so as to reach The Adjutant General at least 90 days prior to the expiration of the officer's current appointment period, and in the event of approval by the Assistant Secretary of War, such reappointment with full privileges will be issued by The Adjutant General.

"The recommendation will include a statement setting forth the officer's occupation and professional standing in civil life; the amount and character of the military work performed by him during the current appointment period; and other pertinent facts regarding the character and the value to the Officers Reserve Corps of the officer concerned. The recommendation will include also a certificate, signed by the chief of arm or service or corps area commander having assignment jurisdiction, to the effect that, to the best of his knowledge and belief, the officer's work in civil life qualifies him for the duties he would be required to perform under his present assignment in time of emergency."

The provisions of the foregoing sections afford a physician an opportunity to continue in the Medical Officers Reserve Corps with eligibility for assignment, active duty and promotion without meeting certain other conditions for reappointment, which include: obtaining a certificate of eapacity for his present grade; or, credit of at least 200 hours of army extension course work, attendance at classes, administrative duties, or active participation with troops on inactive duty training; or completion of a prescribed course of instruction for reserve officers at the special service sehools of his arm or service, or the special course for reserve officers at the Army War College.

In case the reserve officer does not establish his eligibility for reappointment by reason of civil occupation or by one of the methods described in the foregoing paragraph, he may be reappointed to the same grade and section but without eligibility for promotion, assignment and active duty training in peace time.

Any reserve officer who has been reappointed without eligibility for promotion, assignment or active duty in peace time, may regain such eligibility at any time that he fulfills the requirements listed above.

PROMOTION

Basic requirements—Every recommendation for the promotion of a reserve officer must show that all of the following four eonditions have been fulfilled:

1. He holds a certificate of capacity for the next higher grade indicating his professional qualifications. (An exception to this requirement may be made if the officer has a written record of at least 300 hours of army extension work, class work, administrative work or active participation with troops during the five years immediately preceding and prior to October 1, 1930.
2. There is an appropriate vacancy under the peace-time procurement objective of the War Department, except that a vacancy will not be required for promotion from the grade of second lieutenant to first lieutenant.
3. He shall have served a minimum time in his grade.
4. He has during his service in grade, completed at least 14 days of active duty training and has received an efficieney report of at least "satisfactory". When the officer's eivilian pursuits are such as to qualify him, the corps area commander may waive this requirement.

Certificate of capacity—A certificate of capacity for promotion is an instrument in writing which certifies that the officer named therein has met the professional qualifications prescribed for the grade and section specified in the certificate and is issued by the corps area commander.

Such a certificate is obtained after successful completion of a written military knowledge examination and a practical test.

In lieu of written examinations and practical tests, the examining board may accept evidence of satisfactory completion of appropriate courses of instruction for National Guard and Reserve Officers at general and special service schools.

According to information furnished the committee by Colonel Brown, new and interesting Army Extension School courses were provided for Medical Department Reserve Officers with the opening of the Extension School year last October.

These courses cover a number of military subjects which would confront the citizen officer upon assuming his duties as an officer of the Army in time of emergency. Basic courses have been prepared by the staff of the Medical Field Service School, Carlisle Barracks, Pennsylvania, and the more advanced courses have been prepared by the staff of the Command and General Staff School, Fort Leavenworth, Kansas.

The object of the Extension School is to fit the Reserve Officers who finds that he does not have time to devote to active duty training in peace time for the duties which would confront him in time of war. As funds for the active duty training of Reserve Officers are limited and only a few may be trained each year, the Extension School has been a valuable asset in the inactive duty training of Reserve Officers.

During the last school year there were 269 Medical Department Reserve Officers, residents of Ohio, enrolled in the Extension School, indicating much interest on the part of Ohio physicians in improving their knowledge of what would be required of them in time of war.

This committee believes that every physician enrolled in the Officers Reserve Corps who can possibly find the time to do so, should spend several weeks annually in active contact with troops to obtain valuable knowledge of the technical phases of active duty service. Those who

find it impractical to attend camps and training centers for a short period should take advantage of the Extension School courses.

We believe more physicians should take advantage of the practical training with troops which is offered by enrollment in the Ohio National Guard. The medical regiment of the 37th Division, Ohio National Guard, trains each summer at Camp Perry. Some Reserve Officers have enlisted in the National Guard in order to obtain this practical training with troops and others undoubtedly could obtain commissions upon application.

Furthermore, the committee believes that members of the Medical Reserve Corps should join the Reserve Officers' Association through affiliation with their local unit of this organization or the nearest local unit, thereby lending their assistance to the organized effort to sustain interest in and carry out the objectives of the Organized Officers' Reserve Corps.

This committee feels that this report would not be complete without appropriate mention and an expression of sorrow over the death last July 20 of Dr. H. H. Snively, for the past several years chairman of the Committee on Military Affairs of our State Medical Association, and at the time of his death colonel and commanding officer of the Medical Regiment, Ohio National Guard.

Dr. Snively always was intensely interested in activities for the advancement of scientific medicine, the improvement of public health, the promotion of the best interests of the medical profession, and the strengthening of contact between the medical profession of Ohio and the military branches of the government. His untimely death removed from our ranks a capable, competent physician, loved and respected by his colleagues; a soldier whose fortitude had successfully met the tests of active warfare, and an officer of outstanding ability and possessing the full confidence and loyalty of those who had the honor and privilege of serving under him.

This Committee on Military Affairs has endeavored to carry on the work which has been done in a splendid way by previous committees under the chairmanship of Dr. Snively. Anything which the committee has accomplished during the past year was made possible largely because of the foundation for the activities of this committee which had been laid by former committees of which Dr. Snively was the director.

Annual Report of the Councilors

Submitted by S. J. Goodman, M.D., Secretary of Council

Administering the executive affairs of an organization as large, influential and important as the Ohio State Medical Association is a major responsibility. It entails duties which consume much time and effort and call for the exercise of studious, conservative and experienced judgment.

Some idea of the numerous and varied activities of the Council of the State Association during the past year may be obtained by reviewing the minutes of its meetings, published in the June, 1931, August, 1931, November, 1931, January, 1932, and April, 1932, issues of *The Journal*, which should be considered as a primary part of this report.

The individual Councilors of the State Association were called upon to give much time during the past year, because of the abnormal increase in the number and importance of social, economic, governmental, ethical and organization problems arising during that period.

In considering numerous questions affecting scientific medicine, medical practice and public health, the Council has endeavored to base its views and judgments on the sound and long-established policies promulgated by the House of Delegates of the State Association; on the fundamental principles and ethics governing the profession, and on seasoned opinion expressed by those with long experience in medical and public health matters.

The Council in all its activities has tried at all times to be consistent, unbiased and sympathetic. It has given careful study to all questions coming before it. It has attempted to be practical and logical in its conclusions, keeping in mind always the interests and will of the majority of the members of the State Association, and the best interests of the public.

On some of the problems presented to it, the Council has not taken definite action. These are those questions which might be classified as local in scope and affecting in a large measure only a limited portion of the state. The Council believes that the great majority of such questions should be, and can be, settled by the medical profession in the community in which they arise. Of course, the Council has always lent a sympathetic ear to all such questions, but in purely local matters it has been inclined to limit its action to advice and suggestions to members of the profession in the locality affected. We believe that in a democratic organization such as ours, local autonomy should exist to a large degree, especially in questions local, community or sectional in scope and effect.

Close contact has been maintained by the individual members of the Council with the county medical societies and academies in their respective districts. As customary, every Councilor has endeavored to visit each society in his district at least once during the year for the purpose of exchanging ideas and discussing questions of local interest and of state-wide importance. Occasional-

ly circumstances have prevented a Councilor from paying all the societies in his district a visit but this does not in any way indicate that he is not sincerely interested in the affairs of each society and always willing and anxious to be of service to all of them. The contact between the Councilors and the county societies can be strengthened if the secretaries of the various county societies keep the Councilors informed on meeting dates and other matters of mutual interest. Maintenance of a close and systematic contact between the Council and the county societies is essential to good organization. Members of the Council are anxious to serve their constituents and eager to receive in turn their advice, counsel and criticism.

Due to the splendid cooperation and initiative of the officers or a special committee of most of the county medical societies and academies of medicine, the constitutions of the great majority of the societies have been revised to conform to the Constitution and By-Laws of the State Association, in compliance with a mandate issued by the House of Delegates two years ago.

The task of systematizing and modernizing the constitutions and by-laws of the various county societies has been a long, tedious and time-consuming undertaking for the officers of the county societies and the Committee on Constitutional Conformity of the Council, which pases on all drafts before they are submitted to the Council for final approval.

We believe the large amount of work which has been done during the past year by the Committee on Constitutional Conformity, under the chairmanship of Dr. C. L. Cummer, deserves recognition and appreciation from the membership. The conscientious and tireless efforts of this committee and its successor, headed by Dr. Freiberg, have modernized the organic structure of medical organization in Ohio and opened the way for greater cohesion and efficiency in the activities of the State Association and the component county societies.

Another matter to which the Council has given special consideration is that concerning the feasibility of changes in the annual meeting program and set-up, and the possibility of holding the annual meeting in the Fall instead of the Spring, as has been customary.

Since the attitude of the Council toward these questions was outlined in the minutes of the July, 1931, December, 1931, and March, 1932, Council meeting (found in the August, 1931, January, 1932, and April, 1932, issues of *The Journal*, respectively), there will be no attempt to review these matters in this report.

However, the Council earnestly requests and invites the membership to study these questions and offer suggestions concerning them. Since these matters quite likely will come before the House of Delegates for action at the 1932 annual meeting, the Council especially urges members of the House of Delegates to give them thoughtful consideration and obtain, if possible, a concensus of the views of the members of the various county medical societies on them.

In conclusion, the Council presents a tabulation of the membership of the State Association by districts and counties. It will be noted that the membership of the State Association to date this year is less than that of a year ago, due, no doubt to unfavorable economic conditions.

We believe the question of membership in medical organization is relatively more vital and important to the medical profession generally and to each individual physician at the present time than ever before, because of the social unrest, rapid economic and governmental developments, and enormous increase in the number of complex and serious problems confronting the profession.

Every eligible physician should be a member of medical organization, first, because of the many benefits he receives from it, and, second, because of the necessity of maintaining strong and effective organization machinery having the united support of the medical profession.

County societies should impress every eligible physician in their jurisdiction with the valuable services rendered by medical organization and how each physician can safeguard and advance his own interests, as well as the interests of the profession and the public, by actively supporting his local medical society and the State Association.

MEMBERSHIP DATA

First District

John A. Caldwell, M.D., Cincinnati, Councilor

	Paid Membership for 1931	to April 6, 1932
Adams	14	13
Brown	8	8
Butler	82	75
Clermont	20	17
Clinton	25	24
Fayette	20	18
Hamilton	560	505
Highland	17	16
Warren	20	18
	766	694

Second District

E. M. Huston, M.D., Dayton, Councilor

Champaign	23	16
Clark	64	60
Darke	38	31
Greene	34	34
Miami	45	43
Montgomery	277	213
Preble	17	17
Shelby	19	18
	517	432

Third District

O. P. Klotz, M.D., Findlay, Councilor

Allen	75	68

(Third Dist., Cont'd)	Paid Membership for 1931	to April 6, 1932
Auglaize	27	26
Hancock	37	36
Hardin	19	18
Logan	26	26
Marion	44	37
Mercer	16	16
Seneca	39	34
Van Wert	21	22
Wyandot	12	9
	316	292

Fourth District

B. J. Hein, M.D., Toledo, Councilor

Defiance	18	16
Fulton	19	19
Henry	14	11
Lucas	333	272
Ottawa	13	13
Paulding	8	10
Putnam	24	24
Sandusky	37	37
Williams	20	20
Wood	38	30
	524	452

Fifth District

C. L. Cummer, M.D., Cleveland, Councilor

Ashtabula	38	36
Cuyahoga	997	863
Erie	30	27
Geauga	11	8
Huron	22	17
Lake	19	16
Lorain	97	100
Medina	22	25
Trumbull	58	47
	1294	1139

Sixth District

H. S. Davidson, M.D., Akron, Councilor

Ashland	19	20
Holmes	7	8
Mahoning	174	164
Portage	24	24
Richland	59	49
Stark	181	159
Summit	284	220
Wayne	43	43
	791	690

Seventh District

E. B. Shanley, M.D., New Phila., Councilor

Belmont	58	55
Carroll	(With Stark County)	
Columbiana	56	46
Coshocton	22	24
Harrison	8	7
Jefferson	49	41
Monroe	9	9
Tuscarawas	47	42
	249	224

Eighth District

E. R. Brush, M.D., Zanesville, Councilor

Athens	38	35
Fairfield	34	32
Guernsey	28	27
Licking	47	48
Morgan	9	9
Muskingum	51	47
Noble	2	2
Perry	24	19
Washington	35	32
	268	251

Ninth District

I. P. Seiler, M.D., Piketon, Councilor

Gallia	22	22
Hocking	10	12
Jackson	20	17
Lawrence	22	16
Meigs	13	12
Pike	6	5
Scioto	78	73
Vinton	4	4
	175	161

Tenth District

S. J. Goodman, M.D., Columbus, Councilor

Crawford	26	27
Delaware	23	23
Franklin	423	342
Knox	25	24
Madison	13	13
Morrow	8	6
Pickaway	13	11
Ross	41	36
Union	17	17
	589	499
Grand Total	5489	4834

Annual Golf Tourney to be Held at Dayton Country Club

Arrangements have been made for holding the Twelfth Annual Tournament of the Ohio State Medical Golfers' Association at the Dayton Country Club on May 2, the day preceding the opening of the 86th Annual Meeting of the State Association at Dayton.

The Dayton committee in charge of arrangements for the tournament is composed of Dr. J. D. Fouts, chairman, Dr. R. A. Bunn, Dr. M. R. Haley, Dr. H. H. Hatcher, Dr. R. C. Austin, Dr. C. R. Weis and Dr. A. W. Carley. Dr. Fouts, 980 Fidelity Building, Dayton, is accepting entries for the meet.

Any male member of the Ohio State Medical Association is eligible to join the Ohio State Medical Golfers' Association and participate in the meet. Many prizes are offered.

Present officers of the Golfers' Association are: President, Dr. Charles Lukens, Toledo; first vice president, Dr. J. D. Fouts, Dayton; second vice president, Dr. A. L. Jones, Cleveland; third vice president, Dr. D. C. Brennan, Akron; fourth vice president, Dr. Joseph Dunn, Columbus; fifth vice president, Dr. L. M. Otis, Celina, and secretary-treasurer, Dr. J. B. Morgan, Cleveland.

Appelate Court Decision Expected to Deter Judges From Indiscriminate Suspension of Sentences Following Conviction for Violation of Medical Practice Act

Prosecution and punishment of violators of the Medical Practice Act will be accelerated and the state placed in a much stronger position in its efforts to protect the public against unqualified and unlicensed practitioners if a recent decision obtained by Attorney Gilbert Bettman in the Court of Appeals of the Sixth Ohio District is sustained by the Ohio Supreme Court, which, in the opinion of Mr. Bettman, is highly probable, should, by any chance, the decision be appealed.

The victory of Attorney General Bettman and Isadore Topper, special counsel on his staff, in prosecuting and defending an action filed by the State Medical Board against a group of illegal practitioners in Toledo, is believed to be one of importance for law forcement generally, and is of unusual significance from the standpoint of the State Medical Board.

Records of the State Medical Board reveal that during the past few years especially, there has been an excessive tendency on the part of a number of courts to assume an attitude of extreme leniency toward violators of the Medical Practice Act. The most prevalent method used by those courts who presumably are lukewarm in their attitude toward enforcement of the statutory penalties for persons convicted of violating the provisions of the Medical Practice Act, is that of suspending the execution of sentences imposed upon individuals convicted of such violations. In an unusually large number of cases during the past few years where the defendants have been found guilty, the sentences have been suspended or the fines assessed against the defendants never collected.

Obviously, this attitude on the part of a considerable number of courts has proved a serious obstacle to enforcement of the Medical Practice Act and provided clemency for habitual and repeated violators of its provisions.

With efficiency and persistency, the Attorney General's department fought the case arising in Toledo through the various courts as a test case on the right of a court to suspend the execution of sentences, resulting in the decision of the Court of Appeals of the Sixth Ohio District that *the courts of Ohio do not possess the inherent power to suspend sentence in a criminal prosecution except for giving an opportunity for prosecuting error proceedings.*

A second point likewise settled by the Appellate Court decision is that after sentences in such cases have been suspended, the court has the power to set aside the suspension and order the original sentences carried into execution—an angle bearing solely on the case under consideration.

The action on which the important decision was rendered, dates from March 16, 1930. On that date affidavits were filed in the Municipal Court of Toledo by the State Medical Board, charging twenty-two named persons with having violated the provisions of Section 12694, General Code, a section of the Medical Practice Act which makes it unlawful for any person to practice medicine or surgery, or any of its branches, advertise or announce himself as a practitioner of medicine or surgery, or any of its branches, or open or conduct an office for such practice, before obtaining a certificate from the State Medical Board.

The case against Mueller (one of the defendants) was tried before Municipal Judge Leonard Donovan of Toledo. Mueller was found guilty of having violated the law by advertising and announcing himself as a practitioner of chiropractic without having obtained a certificate from the State Medical Board. (See *Ohio State Medical Journal*, issue of September, 1931, Page 732). The defendant was sentenced to pay a fine of $25.00 and costs taxed at $7.10 and to stand committed to the Lucas County jail until said fine and costs were paid or secured to be paid, unless otherwise released according to law.

Mueller filed a petition in error in the Common Pleas Court of Lucas County and upon hearing, the judgment of Municipal Judge Donovan was reversed.

The state, through the Attorney General's department, filed a petition in error in the Lucas County Court of Appeals, which court reversed the judgment of the Common Pleas Court and affirmed the judgment of conviction which had been rendered by Judge Donovan. (*Ohio Law Bulletin and Reporter*, February 29, 1932, Volume 36, Page 88).

Mueller thereupon filed a petition in error in the Supreme Court of Ohio, which court upon consideration dismissed the petition, thereupon sustaining the judgment against the defendant.

After the final disposition of the error proceedings in the Mueller case, on September 25, 1931, the cases against the other persons whose names were set forth in the petition in which Mueller was named as a defendant, were tried before Municipal Judge Donovan. Each was found guilty and sentenced to pay a fine of $25.00 and costs taxed at $5.10, *which sentence was suspended by Judge Donovan.*

Contending that Judge Donovan had no power or authority to suspend the execution of the sen-

tences and that such suspension was not for the purpose of enabling the defendants to perfect error proceedings, the Attorney General on January 6, 1932, filed in the Toledo Municipal Court a motion in each of the cases to set aside the suspension of sentence.

The motions were set for hearing on January 14, 1932, at 1:30 p. m. However, neither Judge Donovan nor any of the other judges of the Toledo Municipal Court appeared to hear the motions, disregarding the request of the Attorney General. Furthermore, no action has been taken since that time by Judge Donovan or the other judges of the Toledo Municipal Court to hear the motions or to set aside the orders suspending the execution of sentences.

Determined to press the case to a final conclusion, Attorney General Bettman, acting through Special Counsel Topper, filed a mandamus action on February 2, 1932, on behalf of Dr. H. M. Platter, secretary of the State Medical Board, in the Court of Appeals, seeking to require the Municipal Court of Toledo and Municipal Judge Leonard Donovan to vacate orders suspending the execution of the sentences imposed in the cases and to direct them to order the enforcement of said sentences. A demurrer was filed by the respondents.

Following careful consideration of the mandamus petition and the demurrer, the Court of Appeals overruled the demurrer and notified the respondents if they do not care to plead further, a final judgment would be entered for the State Medical Board. Up to the present time no appeal to the decision of the Court of Appeals has been filed.

In the words of the Appelate Court, the ultimate questions for determination in this case were "whether the respondents (the Municipal Court of Toledo and Judge Donovan) had authority to suspend the execution of the sentences and whether, after the sentences had been suspended, they had the power to set the suspension aside and order the original sentences carried into execution".

Relative to its reasons for sustaining the arguments presented by the Attorney General and overruling the demurrer, the Court of Appeals said:

"The averments of the petition show very clearly that the orders of suspension were permanent and not made to permit review on error, and that they were not made under the statutes providing for probation of offenders. The plain and necessary effect of the orders of suspension amounts to a refusal on the part of the respondents (the municipal court) to carry out the sentence lawfully imposed and to relieve the accused from the punishment provided by statute and imposed by the court. The provisions of G. C. Section 13451-8, relating to probation were not followed and manifestly were not intended to be followed, for they require that a person against whom a conditional sentence has been awarded shall be committed to an officer of the court until the sentence has been complied with, and if the fine has not been paid within the time limited, the defendant should be committed to the county jail.

"Since the decision in Madjorous vs. State, 113 Ohio St., 427, it is manifest that *the courts of Ohio do not possess the inherent power to suspend sentence in a criminal prosecution except for giving an opportunity for prosecuting error proceedings.* The decision follows very closely the decision of the Supreme Court of the United States in ex parte United States, 242 U. S., 27, in which Chief Justice White in an elaborate opinion demonstrates that the *claimed inherent power of the court to indefinitely suspend execution of sentence has no foundation and that such an order is ultra vires and void.*

"That mandamus against the court or judge is the proper remedy was held by the Court of Appeals of the Sixth Appellate District in State ex rel Doerfler vs. Haserodt, 13 Ohio App., 305, 309. *If the doctrine of the inherent power of a court to suspend sentences indefinitely were followed, it would result in grave injustice to the public.*

"Counsel for respondents rely on Weber v. State, 58 Ohio St., 616, but it is significant that the only question involved in that case was the right of the trial court to set aside an order of suspension at the same term it was made, and it would seem that no one could doubt that the court had such power during the term, whether the suspension were void or valid. All that is said by the court beyond that is obiter and not consistent with the decision of the Supreme Court in Madjorous vs. State, cited supra.

"Counsel for respondents rely on In re Nunley, 102 Ohio St., 332, and Antonio vs. Milliken, 9 Ohio App., 357, but each of these decisions is based on a statute which has since been repealed. *The fact that the legislature has repealed statutes of that character indicates that the power to suspend sentences, when that power existed, was regarded as a source of danger and subject to abuse.*

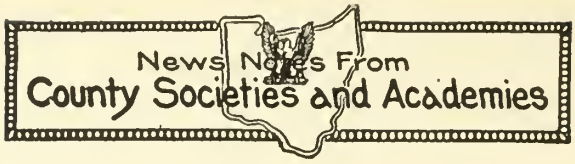
"It is contended that relator had an adequate remedy at law, but we are not impressed with the force of this argument, and its weakness is apparent from the authorities already cited, where the writ had been sustained.

"We are not aware that the state can prosecute error from a judgment of the trial court in a criminal case and Sec. 13452-9, G.C., relied on by respondents, relates only to an order placing a defendant on probation and defined such order as a final one for the purpose of permitting such defendant to prosecute error.

"It is further urged that the Municipal Court has no power to set aside an order of suspension after the term at which it is made. *But the order, being absolutely void, may be set aside at any time or stricken from the docket, or it may be treated as a nullity and the sentence enforced without setting the void order aside.*"

Annual meeting of the American Association for the Study of Goiter will be held at Hamilton, Ontario, June 14, 15 and 16. According to the preliminary program, several Ohio physicians will take part in the program. They are: Dr. Allen Graham, Cleveland; Dr. E. R. Arn, Dayton; Dr. Andre Crotti, Columbus, and Dr. George W. Crile, Cleveland.

Ashtabula—Dr. A. J. Pardee, city health commissioner for the past 12 years, has resigned.



First District

ACADEMY OF MEDICINE OF CINCINNATI

(H. H. Shook, M.D., Secretary)

April 4—General Session. Union Central Building. Program: "Diet, Nutrition and Infection", Dr. Alfred F. Hess, New York City.

April 11—Medical Section. Union Central Building. Program: "Vivian Neuralgia", Dr. Harris H. Vail. Discussion opened by Dr. William Mithoefer. "Some Mistakes in Microscopic Diagnosis of Tumors", Dr. Charles Goosmann.

April 18—Specialty Section. Union Central Building. Program in charge of the Radiological Section: "Radiation Therapy of Carcinoma of the Cervix Uteri", Dr. Justin E. McCarthy; "Recent Results and Advances in Roentgen Ray and Radium Therapy", Dr. Sidney Lange; "Roentgenological Studies of Bone Tumor", Dr. George Benzing, Jr.; "Interlobar Pleurisy", Dr. Samuel Brown; "Roentgenological Aspects of Abdominal Masses", Dr. H. G. Reineke and Dr. William H. McGehee. Discussion opened by Drs. E. R. Bader and Carl W. Koehler.

April 25—General Session. Union Central Building. Members of the Cincinnati Dental Society guests of the Academy. Program: "The Systemic Cause and Effect of Dental Diseases", by Arthur H. Merritt, D.D.S., New York City.

Butler County Medical Society met in regular session March 11 at Middletown with an attendance of 27. Dr. Walter Henry Roehll, Middletown, presented a paper on "Bacteriophage", a subject on which he has been conducting research work for the past three years.—Harold O. Lund, M.D., Secretary.

Clinton County Medical Society held its regular meeting March 1 at the General Denver Hotel, Wilmington. Following the presentation of case reports by various members of the society, two illustrated lectures were given. Dr. S. W. Mulholland, Springfield, spoke on "Mechanism of Vesical Neck Obstruction and Its Treatment". Dr. Roy D. Arn, Springfield, presented a paper on "Vascular Diseases of the Extremities".—William L. Regan, M.D., Secretary.

Fayette County Medical Society devoted its regular meeting on April 7 to a celebration of the 50th anniversary of Koch's discovery of the tuberculosis bacillus. Forty-five physicians from Fayette and adjoining counties gathered at 1 p. m. at the Y.M.C.A., Washington C. H. Following a "Dutch Treat" luncheon, a paper was read By Dr. C. H. Benson, Columbus, on "Early Diagnosis of Pulmonary Tuberculosis", supplemented by case histories and *X*-ray films presented by Dr. L. H. Senteff, Chillicothe. Dr. Senteff also made several demonstrations on performing pneumothorax. It was decided to cancel the May meeting of the society so that members could attend the annual meeting of the State Association at Dayton.—James F. Wilson, M.D., Secretary.

Highland County Medical Society at its regular meeting on March 10 at Hillsboro, was addressed by Dr. Carl A. Wilzbach, Cincinnati, on "The Cause, Prevention and Control of Cancer". Following the meeting, dinner was served.—News Clipping.

Second District

Clark County Medical Soeiety was addressed by Dr. A. Graeme Mitchell, professor of pediatrics, College of Medicine, University of Cincinnati, at its meeting on March 9 at the Shawnee Hotel, Springfield. Dr. Mitchell discussed the subject, "Is the Feeding of Infants Simple or Complex?" A general discussion followed the address which referred especially to the technic of artificial feeding of babies during the first year. Among those who discussed the question were: Drs. C. H. Hiestand, E. H. Long and J. C. Easton.

One of the largest turn-outs in the history of the society was present at the March 23 meeting of the society at the Heaume Hotel to hear an address by Dr. Raphael Isaacs, University of Michigan, on "Some Features in the Diagnosis and Treatment of Anaemia". Dr. Isaacs is an associate of Dr. C. C. Sturgis of the Simpson Memorial Institute, University of Michigan, which is conducting research work on anemia. The 62 physicians and guests who attended were unanimous in their opinion that the address was one of the most interesting and beneficial ever given before the society.—Edward C. Nehls, M.D., Secretary.

Miami County Medical Society held its regular monthly meeting April 1 at the Stouder Memorial Hospital, Troy. An interesting paper on "Surgical Treatment of Gastric Ulcer," illustrated by a four-reel motion picture, was presented by Dr. J. F. Beachler, Piqua.—G. A. Woodhouse, M.D., Secretary.

Montgomery County Medical Society at its regular meeting April 1 at the Dayton-Biltmore Hotel, Dayton, observed the 50th anniversary of the discovery of the tubercle bacillus by Koch.

During the day many physicians and others visited the Stillwater Tuberculosis Sanatorium, which held open house for the public. In the evening, the society and their guests were addressed by Dr. Stuart Pritchard, medical director of the W. L. Kellogg Foundation, Battle Creek, Michigan, on "Koch and the Discovery of the Tubercle Bacillus As It Affects Our More Recent Concepts of This Disease". Following the meeting a buffet supper was served.

At a regular meeting of the society on April 15, Dr. Robert T. Finley and Dr. C. J. Mardis presented a symposium on "Ambulatory Treatment of Varicose Veins".—Bulletin.

Preble County Medical Society met in regular session March 17 at the Seven Mile Tavern near Eaton. The principal speaker of the evening was Dr. Benedict Olch, Dayton. Dr. Olch spoke on "The Management of Diabetes Mellitus". A dinner preceded the program.—News Clipping.

Third District

Hardin County Medical Society held a luncheon meeting March 29 at the Martin Restaurant, Kenton. Dr. Charlton B. Pierce, University of Michigan, Ann Arbor, was the guest speaker. He presented a paper on "X-ray Diagnosis of the Chest". —News Clipping.

Mercer County Medical Society at its regular meeting March 10 witnessed a motion picture film showing the harvesting and manufacture of drugs, shown through the courtesy of Flint, Eaton and Company.—News Clipping.

Seneca County Medical Society held a golden anniversary celebration on the evening of March 17 at the Shawan Hotel, Tiffin, in honor of Dr. H. L. Wenner, Tiffin, and Dr. N. C. Miller, Fostoria, who recently completed 50 years active practice of medicine. The meeting was attended by about 40 physicians from Seneca and surrounding counties. Among those present were Dr. J. H. Burnett, Fostoria, who has completed 52 years of active practice and Dr. J. H. Norris, Fostoria, who has been practicing for 55 years. The guest speaker was Dr. C. D. Selby, Toledo. Dr. Selby congratulated Dr. Wenner and Dr. Miller on their long service and complimented the society on the enrollment of so many veterans and experienced physicians. He then addressed the society on "Injuries of the Skull and Brain".—News Clipping.

Van Wert County Medical Society at its regular meeting April 5 was addressed by Judge H. L. Conn on "The Doctor as a Witness".—News Clipping.

Fourth District

ACADEMY OF MEDICINE OF TOLEDO AND LUCAS COUNTY

(A. P. Hancuff, M.D., Secretary)

April 1—General Session. Program: Debate—"Resolved, That Compulsory Health Insurance is a Beneficial Factor in the Economics of Medicine", Dr. W. W. Beck, affirmative; Dr. A. P. Hancuff, negative. Affirmative discussants, Drs. L. R. Effler, F. L. Eyestone, B. J. Hein, E. W. Huffer and C. D. Selby; negative discussants, Drs. T. H. Brown, Paul Hohly, J. T. Murphy, J. J. Sweeney and C. W. Waggoner. A buffet luncheon was served at the University Club following the meeting.

April 8—Section on Pathology, Experimental Medicine and Bacteriology. Program: "Electrosurgery of Tonsils", Dr. Frederick B. Palmer, Northwestern University.

April 15—Medical Section. Program: Clinical Pathological Symposium under the direction of Dr. L. C. Grosh. Demonstrations by Dr. Bernhard Steinberg on: "Influenza Pneumonia with Carcinoma of the Stomach and Multiple Metastasis", "Glomerular Nephritis", and "Nephrosclerosis". Discussants: Drs. J. L. Stifel, L. A. Levison, and K. D. Figley.

April 22—Surgical Section. Program: "Diagnosis and Treatment of Empyema in Children", Dr. Grover C. Penberthy, associate professor of surgery, Detroit College of Medicine and Surgery.

Four County Medical Society at its regular meeting March 29 at the Kettenring Golf Club, Defiance, was addressed by Dr. George W. Crile and Dr. Russell L. Haden, Cleveland. Dr. Crile spoke on "Certain Indications for Adrenal Denervation", and Dr. Haden on "Types of Treatment of Chronic Arthritis". A dinner was served following the program.—News Clipping.

Wood County Medical Society met in regular session March 17 at the Women's Building, Bowling Green. Following a dinner at which 15 members were present, Dr. Berman S. Dunham, Toledo, gave an interesting and instructive paper on "Artificial Feeding of Infants".—R. N. Whitehead, M.D., Correspondent.

Fulton County Medical Society entertained the board of trustees of the Memorial Hospital, the county commissioners and township trustees at a dinner in Community Hall, Delta, March 24. Following the dinner talks were made by Dr. B. J. Hein, Toledo, councilor of the Fourth District; on "The Indigent Patient" and Dr. W. W. Brand on "The Relation of the Hospital to the Community".—News Clipping.

Sandusky County Medical Society held its regular meeting March 31 in the Council Chamber, Fremont. The guest speaker was Dr. Norris W. Gillette, Toledo, who spoke on "Goiter". Motion pictures furnished by the American College of Surgeons were shown.—News Clipping.

Fifth District

ACADEMY OF MEDICINE OF CLEVELAND

(Clarence H. Heyman, M.D., Secretary)

April 1—Clinical and Pathological Section.

Demonstration at Charity Hosiptal.

April 8—Eperimental Medicine Section. Institute of Pathology. Program, arranged by the Department of Pediatrics: "Observations on the Bacteria-Inhibitory Properties of the Duodenal Juice of Infants and Children", Dr. G. Richard Russell; "Culture of Tubercle Bacilli from the Body Fluids as a Routine Diagnostic Measure", Dr. H. S. Reichle and Dr. E. M. Wier; "Tuberculin Reaction in Measles and Scarlet Fever", Dr. J. D. Pilcher; "Demonstration of a Toxic Factor in the Stools and Urines of Poliomyelitis Patients", Dr. J. A. Toomey; "Rickets and Tetany in Rats in Relation to the Acid-Base Content and to the Calcium Phosphorous", Dr. Alfred T. Shohl, Catherine S. Rose, A.B., and Esther M. Saurwein, A.B.; "The Efficacy of Spray-Dried Orange Juice in Human and Animal Scurvy", Dr. Henry J. Gerstenberger, Dr. G. L. Hacker, and Donald N. Smith, B.S.

April 20—Industrial Medicine and Orthopedic Section. Lakeside Hospital. Program: "Rupture of the Aorta—Report of Two Cases", Dr. Alan R. Moritz; "Fractures of the Neck of the Femur", Dr. C. H. Heyman; "Pyogenic Infections of the Spine", Dr. Maxwell Harbin; "Tumors of the Spine", Dr. J. C. Pickett.

April 22—Combined meeting of Ophthalmological, Otolaryngological and Pediatric Sections. Cleveland Club. Program: "Otolaryngological Affections in Infancy and Childhood": from the viewpoint of the pediatrician, Dr. C. W. Wyckoff and Dr. O. L. Goehle; from the viewpoint of the otolaryngologist, Dr. C. E. Pitkin and Dr. I. F. Weidlein; "Ophthalmological Affections in Infancy and Childhood", Dr. R. B. Metz.

Erie County Medical Society at its meeting on March 29 at the Sunyendeand Club was addressed by Dr. Louis J. Karnosh, Cleveland. Dr. Karnosh spoke on "Phychopathic Personalities of Famous People".—News Clipping.

Lake County Medical Society held a well-attended meeting March 22 at the Lake County Memorial Hospital, Painesville, with Dr. W. P. Ellis, the president presiding. The program was on "Chromium Poisoning". The subject was discussed at length by Dr. William J. Mears, Englewood, N. J., physician for the Standard Chromate Company of that city. Dr. Mears was accompanied to Painesville by J. O. Krosse and A. L. Geisinger, manager and vice president of the plant, who were guests of the society. Dr. C. L. Cummer, Cleveland, councilor of the Fifth District, was present and took part in the discussion which followed the program. A dinner was served following the meeting.—News Clipping.

Medina County Medical Society held its regular meeting March 17 at the Evanon Inn, near Medina. A large turn-out listened to an address on "Craniocerebral Injuries", by Dr. John Dickenson, Cleveland, which was practical and based on good clinical experience. Dr. C. L. Cummer, Cleveland, councilor of the Fifth District, was present and spoke briefly on organization activities. Dr. Charles A. Bolich, Wadsworth, was congratulated on the celebration of his 35th anniversary in the practice of medicine and, following a short speech on appreciation, passed the cigars. It was announced that the membership of the society had reached 25, as large a membership as the society has ever had.

On April 7, the society held a meeting at the inn and was addressed by Dr. H. H. Dorr, chief medical examiner for the State Industrial Commission.—J. K. Durling, M.D., Secretary.

Sixth District

Union Medical Association comprising the societies of the Sixth District met Wednesday, April 13, at the University Club, Akron. Dr. Charles A. Lamont, Canton, president of the association presided. The program consisted of four papers, namely: "Anal Pruritis", Dr. George Wenger, Massillon; "Surgery of the Knee Joint", Dr. Maxwell Harbin, Cleveland; "Pneumonia", Dr. A. M. Rosenblum, Youngstown, and "The Relation of Sinus Disease to Asthma", Dr. D. S. Arbuckle, Akron. A brief business session was held following a luncheon at noon. Other officers of the association are Dr. J. H. Seiler, Akron, secretary, and Dr. H. S. Davidson, Akron, councilor.

Summit County Medical Society met in regular session April 5 at the Akron City Club. The guest speaker was Dr. R. L. Haden, Cleveland, who spoke on "The Problem of Chronic Arthritis".—A. S. McCormick, M.D., Secretary.

Eighth District

Fairfield County Medical Society held a luncheon meeting March 8 at the Florentine, Lancaster. Following a business session, the society was addressed by Dr. P. J. Reel, Columbus, on "Fibroids".—News Clipping.

Guernsey County Medical Society held its first quarterly jubilee meeting on March 17 at the Berwick Hotel, Cambridge. A three-course dinner was enjoyed by members of the society and their wives after which a program of stunts and games was presented. The committee in charge of the affair was composed of Dr. B. A. Souders, Dr. C. C. Headley, Mrs. J. E. Patton, Mrs. H. R. Neeland and Mrs. Clyde Vorhies. Prizes were won by Mrs. B. A. Souders, Mrs. C. A. Craig, Dr. Fred Lane and Dr. O. R. Jones.—News Clipping.

Licking County Medical Society was addressed by Dr. H. L. Reinhart, Columbus, at its regular meeting March 25 at the Warden Hotel, Newark. Dr. Reinhart presented a paper on the "Aschheim-Zondek Test for Pregnancy".—News Clipping.

Muskingum—The Muskingum County Academy of Medicine held a dinner meeting April 6 at the Zane Hotel. Following the dinner, the academy was addressed by Dr. Albert H. Freiberg and Dr. Moses Salzer, of Cincinnati. Dr. Freiberg spoke on "Reconstruction Surgery in Arthritis" and Dr. Salzer on "Incidence of Syphilis in Private Practice".—Beatrice T. Hagen, M.D., Secretary.

Perry County Medical Society held its regular meeting March 21 at the Park Hotel, New Lexington. The program was in charge of Dr. Edgar Allen, Crooksville. The guest speaker was Dr. E. H. Baxter, Columbus. Luncheon was served preceding the program.—F. J. Crosbie, M.D., Secretary.

Ninth District

Scioto—The Hempstead Academy of Medicine met in regular session on March 14 at the recreational hall of the nurses' home. Guest speakers were John H. Fougler, assistant professor of pharmacy, University of Cincinnati, and Dr. Samuel Iglauer, Cincinnati. Dr. Iglauer spoke on "Deep Infections of the Neck". The program was arranged by Dr. C. L. Ferguson. Following the program, a buffet supper was served.—News Clipping.

Hocking County Medical Society met in regular session at the Easterling Club, Logan, March 30. Following a dinner, Dr. J. P. Farson, Columbus, addressed the society on "Infant Feeding". The meeting was well attended.—News Clipping.

Tenth District

COLUMBUS ACADEMY OF MEDICINE

(John H. Mitchell, M.D., Secretary)

April 4—General Session. Columbus Public Library. Program: "Our Present Chemical Point of View With Reference to Sugars", Dr. William Evans, Ohio State University.

April 11—General Session. Columbus Public Library. Program: "Arteriosclerotic Heart Disease, Considering Pathology, Symptomatology and Treatment", Dr. Harold E. B. Pardee, Cornell University Medical College.

April 18—General Session. White Cross Hospital. Program: Clinic by the hospital staff.

April 25—General Practitioners Section. Columbus Public Library. Program: "Some Manifestations of Hypertension", Dr. Frank Warner; "Head Injuries from the Standpoint of the General Practitioner", Dr. Harry LeFever.

Crawford County Medical Society held its regular meeting April 4 at the Elks' Home, Bucyrus. The guest speaker was Dr. E. Benton Conoway, D.D.S., Columbus, who spoke on "Eradication of Dental Infections—Their Diagnosis and Relation to the Physician and Dentist". Slides were used by the speaker to illustrate his talk. Following the program a buffet supper was served.—A. E. Loyer, M.D., Secretary.

Delaware County Medical Society at its meeting March 15 at Hoffman's Colonial room, Delaware, was addressed by Dr. W. D. Inglis and Dr. Thomas A. Vogel, of Columbus. Dr. Inglis spoke on "The Modern Care of Normal Pregnancy" and Dr. Vogel on "The Pathology of Pregnancy". Members of the Union County Medical Society were guests.—News Clipping.

NEWS NOTES of OHIO

Columbus—Dr. Wynne M. Silbernagel, who recently returned to Columbus, is now associated with Dr. Wayne Brehm, 683 East Broad Street, in the practice of obstetrics and gynecology, together with Dr. Ralph E. Ramey. Dr. Silbernagel received his B.S. degree from Denison University and his M.D. degree from Jefferson Medical College. He has had two years of special training in obstetrics at Jefferson Medical College and in Cleveland.

Gallipolis—A community banquet was given recently at the Lafayette Hotel honoring Dr. Charles A. Rife, Kyger, on the occasion of his golden anniversary as a practicing physician. Many of Dr. Rife's professional colleagues, neighbors, friends, and relatives attended. Among those who spoke in appreciation of Dr. Rife's long and faithful service to the community were: Dr. C. E. Holser, Dr. J. T. Hanson, Dr. O. A. Vornholt and Judge R. J. Mauck. The honored guest was presented with a purse containing $60 in gold, a gift of the Gallia County Medical Society which sponsored the celebration.

Andover—Dr. Paul J. Collander, Ashtabula, Finnish vice consul and president of the Ashtabula County Medical Society, was a recent speaker before the Andover Chamber of Commerce. He spoke on his native country and illustrated his talk with lantern slides.

Wilmington—Dr. Kelly Hale has been notified of his appointment to membership in the American Association for the Advancement of Science.

Xenia—Trustees of the Ohio Soldiers' and Sailors' Orphans' Home adopted a resolution of appreciation for the service performed by members of the medical profession and nurses during the recent influenza epidemic at the institution. Among those cited in the resolution are: Dr. A. C. Messenger, resident physician, and Drs. Ben R. McClellan, R. R. McClellan, R. H. Grube, H. C. Messenger, Reed Madden, Lawrence Shields, T. F. Myler and Marshall Best.

Spencerville—Dr. J. R. Welch, a pioneer physician of Allen County, recently celebrated the 50th anniversary of his entrance into the practice of medicine.

Columbus—Dr. and Mrs. Joseph Price, Dr. and Mrs. R. B. Drury, and Dr. and Mrs. I. B. Harris have returned from a month's cruise through the West Indies.

Uhrichsville—Dr. J. A. McCollam was cut and bruised when his automobile skidded near here and crashed into a tree.

Columbus—Dr. Charles A. Doan, head of the department of surgical research, College of Medicine, Ohio State University, has been appointed by the Board of Trustees of the American Medical Association to succeed Dr. William F. Petersen on the Division of Medical Sciences, National Research Council.

Cincinnati—The following changes and appointments in the faculty of the College of Medicine, University of Cincinnati, have been announced by the board of trustees: Dr. Frank M. Coppock promoted from assistant professor to associate professor of gynecology; Dr. John M. Stark and Dr. V. B. Roberts promoted from instructors to assistant professors of gynecology; Dr. Mabel Gardner and Dr. Joseph Heiman promoted from assistants to instructors in gynecology; Dr. John H. Phair, assistant in bacteriology; Dr. Hubert Shook, to instructor in medicine; Dr. Gerald Castle, to assistant in gynecology, and Dr. Maurice Levine to research associate in psychiatry and Stearns scholar in psychiatry.

Lewisburg—Dr. Karl W. Horn, who has been engaged in active practice here for the past nine years, has moved to Ann Arbor, Michigan, where he has accepted a position on the staff of the University of Michigan Hospital.

Mt. Vernon—The Bladenburg Parent-Teacher Association was addressed recently by Dr. Julius Shamansky, city health commissioner.

Cumminsville—Dr. Evalyn M. Partymiller has opened offices for general practice here. She is a graduate of the College of Medicine, University of Cincinnati.

Chagrin Falls—Dr. V. C. Kenney addressed the local Kiwanis Club recently on "The History of Medicine".

Cincinnati—Dr. W. D. Haines addressed the Cincinnati Reserve Officers' Association, meeting at the Hotel Gibson.

Youngstown—Dr. David A. Belinky, graduate of the Temple University Medical School, has opened an office for active practice here, his home city.

HOSPITAL NOTES

—Staff officers have been re-elected as follows at St. Mary Hospital, Cincinnati; President, Dr. George B. Topmoeller; vice president, Dr. William A. Teveluwe, and secretary, Dr. Benjamin J. Hoyer.

—Staff officers at Good Samaritan Hospital, Cincinnati, have been elected as follows: Chief of staff, Dr. E. A. Wagner; vice president, Dr. Ralph Carothers; secretary, Dr. Clifford J. Straehley; executive board, Drs. Wagner, Straehley, Carothers, Eslie Asbury, Edward King and Oscar Berghausen.

—Staff appointments have been made as follows at the Findlay Home and Hospital: Chief of staff, Dr. J. C. Tritch; vice chief of staff, Dr. J. V. Hartman; surgical staff, Drs. J. M. Firmin, J. V. Hartman, J. H. Marshall, J. C. Tritch; obstetrics, Dr. D. B. Biggs; medical staff, Dr. E. J. Thomas, Dr. F. M. Wiseley; eye, ear, nose and throat, Dr. H. R. Wynn and Dr. W. J. Fishell; visiting staff, Drs. Don C. Hughes, W. B. Keator, D. J. King, A. H. Linaweaver, E. W. Misamore, R. D. Whisler, T. S. Wilson, E. B. Harrington, O. P. Klotz, P. C. Pennington, E. E. Rakestraw, T. A. Spitler, H. O. Crosby, A. E. Mann; secretary of staff, Dr. J. H. Marshall.

—Dr. Jonathan Forman has been re-elected chief of staff at Grant Hospital, Columbus, and Dr. Drew L. Davies, secretary. Dr. Hugh A. Baldwin was named director of surgery; Dr. E. F. McCampbell, director of medicine; Dr. S. J. Goodman, director of obstetrics; Dr. Carl D. Postle, director of eye, ear, nose and throat.

—At a recent organization meeting, the staff at White Cross Hospital, Columbus, elected Dr. C. D. Hoy, chief of staff, and Dr. John H. Mitchell, secretary. Heads of the various departments are: Surgery, Dr. Fred Fletcher; medicine, Dr. W. F. Millhon; obstetrics, Dr. G. Wayne Brehm; eye, Dr. Albert Frost, orthopedics, Dr. Hoy; gynecology, Dr. William P. Smith; ear, nose and throat, Dr. Russell G. Means; urology, Dr. A. B. Landrum; proctology, Dr. Edward A. Hamilton; dentistry, Dr. Gale F. Powell; bronchoscopy and plastic surgery, Dr. Hugh G. Beatty; pediatrics, Dr. A. G. Helmick; electro-cardiology, Dr. R. W. Kissane; chest, Dr. Louis Mark; laboratories, Dr. Ernest Scott; *X*-ray and dermatology, Dr. H. V. Weirauk, and anesthesia, Dr. E. C. Ludwig; neuro-psychiatry, Dr. George T. Harding, Jr., Dr. John W. Wright was made staff member emeritus.

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Deaths in Ohio

David R. Alban, M.D., Columbus; Medical College of Ohio, Cincinnati, 1890; aged 68; member of the Ohio State Medical Association and a Fellow of the American Medical Asociation; died March 16 following a stroke. Dr. Alban had practiced in Jackson County, his native county, and in Ironton before moving to Columbus in 1902. Surviving are his widow, one son, Dr. D. E. Alban, Columbus, one daughter, one brother and five sisters.

Edward E. K. Chapman, M.D., Defiance; Hahnemann Medical College and Hospital, Chicago, 1888; aged 73; former member of the Ohio State Medical Association and the American Medical Association; died March 25 of heart trouble. Dr. Chapman was born at Cassopolis, Michigan, moving to Defiance shortly after graduating from medical school. For sixteen years, Dr. Chapman served as coroner of Defiance County; was for a time city health commissioner, and was a former president of the Northwestern Ohio Medical Association. Dr. Chapman leaves his widow, three sons and one sister.

George P. Dale, M.D., Dayton; Miami Medical College, Cincinnati, 1900; aged 59; member of the Ohio State Medical Association and a fellow of the American Medical Association; died March 19 following an operation. Dr. Dale was a native of Cincinnati, locating in Dayton in 1902. He was a member of various Masonic orders, a charter member of the Dayton Kiwanis Club and a member of the Grace Methodist Episcopal Church. He is survived by three brothers and three sisters.

Paul S. Fishbaugh, M.D., Van Wert; College of Medicine, Ohio State University, 1922; aged 37; member of the Ohio State Medical Association and of the American Medical Association; died March 17 of intestinal trouble. Dr. Fishbaugh was a native of Mendon and had been practicing in Van Wert since 1927. He is survived by his widow, one son, one daughter, his parents, one brother and two sisters. His father is Dr. P. W. Fishbaugh of Mendon.

Charles V. Garver, M.D., Lorain; School of Medicine, Western Reserve University, 1902; aged 56; member of the Ohio State Medical Association and a fellow of the American Medical Association; died March 25 following an extended illness. Dr. Garver, a native of Wayne County, spent practically all his life in Lorain County. He was a past president of the Lorain County Medical Society; former county coroner; past president of the St. Joseph's Hospital staff, and was chief of the obstetrics staff of that hospital at the time of his death. Dr. Garver had always been active in social and civic affairs. He was a member of the Church of the Redeemer, Royal Arcanium, Rotary Club and Inter-Club Council. Surviving are his widow, one son, Dr. William P. Garver, Cleveland, one daughter, six brothers and two sisters.

Alexander Gilfillen, M.D., Russellville; Medical College of Ohio, Cincinnati, 1876; aged 82; former member of the Ohio State Medical Association and the American Medical Association; died March 15 following a year's illness. Dr. Gilfillen retired three years ago after 53 years in active practice. He is survived by one son, Dr. G. C. Gilfillen, Dayton, and one daughter.

Charles L. H. Hintzelmann, M.D., Cleveland; University of Wooster, Medical Department, Cleveland, 1878; aged 81; died March 25. Dr.

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Hintzelmann, a native of Germany, had practiced for 54 years among the German citizens of West Cleveland. Surviving is one son.

William L. Keller, M.D., Akron; Medical College of Ohio, Cincinnati, 1901; aged 60; died March 7, following a gall bladder operation. Dr. Keller had been practicing in Akron for the past 30 years, moving there from Alliance, his native city. Besides his widow, Dr. Keller leaves one son, his father and one brother.

Charles B. Langsam, M.D., Cleveland; Hahnemann Medical College, Philadelphia, 1925; aged 34; member of the Ohio State Medical Association and the American Medical College; died March 22. Dr. Langsam was born and educated in Lorain. Following graduation from medical school he located in Cleveland where he was on the associate staff of the Polyclinic and Mt. Sinai hospitals. Surviving are his widow and one daughter.

James Lytle Moore, M.D., Toledo; Toledo Medical College, 1907; aged 48; former member of the Ohio State Medical Association and the American Medical Association; died March 5. Dr. Moore had been in ill health for the past three months. Surviving are his widow, one daughter, his father, one brother and one sister.

Orville O. McKee, M.D., Caldwell; University of Michigan Medical School, 1882; aged 78; died March 8 after a lingering illness. Dr. McKee retired from active practice several years ago and devoted his later years to management of his extensive farming and business interests. He leaves his widow and one daughter.

Clifton Stratford Morse, M.D., Canton; Starling Medical College, Columbus, 1880; aged 64; died March 4 from pneumonia. Dr. Morse leaves his widow, one son and one sister.

Harry H. Myers, M.D., Alliance; School of Medicine, Western Reserve University, 1910; aged 48; former member of the Ohio State Medical Association and the American Medical Association; died March 19 from self-inflicted wounds. Dr. Myers from 1919 to 1924 was personnel director for the Ohio Brass Company, Mansfield, and connected with the Frigidaire Company, Dayton, in the same capacity for four years. He recently published a book, "Human Engineering", in which he summarized his experiences in industrial medicine and in handling the personnel of large industries. He is survived by one sister and one brother.

Elmer C. Raudebaugh, M.D., West Salem; Starling Medical College, Columbus, 1896; aged 62; died February 13 from influenza. Dr. Raudebaugh was a native of Wayne County. Following his graduation from medical school, he practiced for a time at Lattasburg and Overton, moving to West Salem in 1907. Dr. Raudebaugh belonged to the Masonic, Maccabee, Rebekas and Odd Fellows lodges. He leaves his widow, two sons, four brothers and three sisters.

Parker B. Robinson, M.D., Toledo; School of Medicine, Northwestern University, 1904; aged 57; former member of the Ohio State Medical Association and the American Medical Association; died March 21 from heart trouble. Dr. Robinson was former fleet surgeon and physician for the Inter-Lake Yachting Association. Surviving are his widow, four sons, one daughter, one brother and one sister.

Isaac M. Schrader, M.D., Bowling Green; Eclectic Medical College, Cincinnati, 1882; aged 79; former member of the Ohio State Medical Association; died March 6. Dr. Shrader before locating in Bowling Green in 1904 had practiced at Sunbury and Sterling. He was a Mason and past exalted ruler of the Bowling Green Elks' Lodge. Surviving are his widow, one son, two sisters and one brother. Another son, Dr. C. O. Shrader, died in 1918.

Thomas A. Speidel, M.D., Felicity; Medical College of Ohio, Cincinnati, 1904; aged 50; member of the Ohio State Medical Association and of the American Medical Association; died March 10 of pneumonia. Dr. Speidel was well known through Clermont and Brown counties. He was a Mason. Surviving are his widow, two daughters, and three brothers.

David William Stevenson, M.D., Akron; Rush Medical College, Chicago, 1890; aged 66; former member of the Council, Ohio State Medical Association, and a Fellow of the American Medical Association; died March 29 of heart disease. Dr. Stevenson, for many years one of the most prominent and active physicians of eastern Ohio in the activities of medical organization, was elected to the Council of the Ohio State Medical Association from the Sixth District in 1920. He retired from the Council in 1931 after 10 years of valuable and faithful service. Dr. Stevenson was born in Milton, Ontario, Canada, January 15, 1866. He received his B.Sc., degree from the University of Toronto in 1887 and graduated from Rush Medi-

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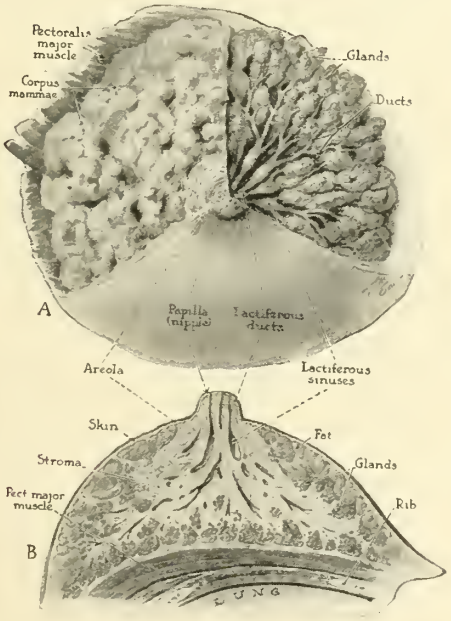
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cal College in 1890. Dr. Stevenson was a former president of the Summit County Medical Society. He was a Fellow of the American College of Surgeons, member of the American Academy of Ophthalmology and Oto-Laryngology, and the holder of a certificate from the American Board of Oto-Laryngology. Dr. Stevenson's brother, Dr. Mark D. Stevenson and a daughter, Dr. Jane Lawrence Stevenson preceded him in death. Another daughter, Dr. Marion Hope Stevenson, resides in Detroit.

James A. Tyler, M.D., Columbus; Columbus Medical College, 1892; aged 61; died March 21. He was the oldest practicing colored physician in Columbus. He leaves his widow, a step-son, Dr. J. H. Wilson, four brothers and two sisters.

Edward F. Waddle, M.D., Chillicothe; College of Physicians and Surgeons, Baltimore, 1883; aged 72; member of the Ohio State Medical Association and of the American Medical Association; died March 9 of kidney trouble. Dr. Waddle, a native of Chillicothe and the son of the late Dr. William Waddle, had practiced in that city since his graduation from medical school. He was a captain in the medical corps during the Spanish-American War and was at one time a surgeon for the Baltimore & Ohio Railroad. He leaves three sisters.

Dickerson H. Welling, M.D., Worthington; Eclectic Medical College, Cincinnati, 1878; aged 84; died March 18. Dr. Welling was a native of Harrison County. Following the Civil War, in which he served at the age of 17, he moved with his two brothers to Worthington. Following his graduation from medical school, he practiced medicine in Brown Township, Franklin County for 10 years, later moving to Worthington where he had practiced for the past 41 years. He was for several years medical director for the State G. A. R. He leaves his widow, one daughter and one son.

Roderick B. Wittich, M.D., Columbus; Bellevue Hospital Medical College, New York, 1895; aged 61; former member of the Ohio State Medical Association and the American Medical Association; died February 28 of diabetes. Dr. Wittich moved to Columbus in 1920 from Mt. Sterling where he had practiced for 25 years. During the World War he saw active service with the Medical Corps. He is survived by his widow, one son and one sister.

Albert Wood, M.D., Medina; School of Medicine, Western Reserve University, 1892; aged 72; member of the Ohio State Medical Association and the American Medical Association; died February 17 of a heart attack. Dr. Wood had practiced in Medina County for 40 years. He was a native of England. Surviving are his widow, one son and three daughters.

KNOWN IN OHIO

Robert C. Fleming, M.D., Louisville, Kentucky; College of Physicians and Surgeons, Baltimore, 1900; aged 55; former member of the Ohio State Medical Association; died February 12. Dr. Fleming was a former resident of Van Wert, where he served two terms as county coroner, moving to Louisville in 1917. He was a World War veteran. He is survived by a brother of Louisville.

Augustus F. House, M.D., Los Angeles; College of Physicians and Surgeons, Cleveland, 1871; aged 84; former member of the Ohio State Medical Association; died February 2 at Los Angeles and was buried in Cleveland, February 8. Dr. House was a native of Cleveland and practiced there until 1913 when he retired and moved to California. He was a Civil War veteran, having been with Sherman on his march to the sea. For many years Dr. House occupied the chair of surgery at the College of Physicians and Surgeons. He was one of the co-organizers of the National Screw and Manufacturing Company and the National Acme Company. He is survived by two daughters, Mrs. Cyrus S. Eaton, Cleveland, and Mrs. Thomas A. McNamara, Los Angeles.

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The OHIO STATE MEDICAL JOURNAL

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THE OHIO STATE MEDICAL ASSOCIATION
AS A MEDIUM OF SERVICE TO ITS MEMBERS

JUNE 1, 1932 VOLUME XXVIII Number - - - 6

JUN 1
MEDICAL

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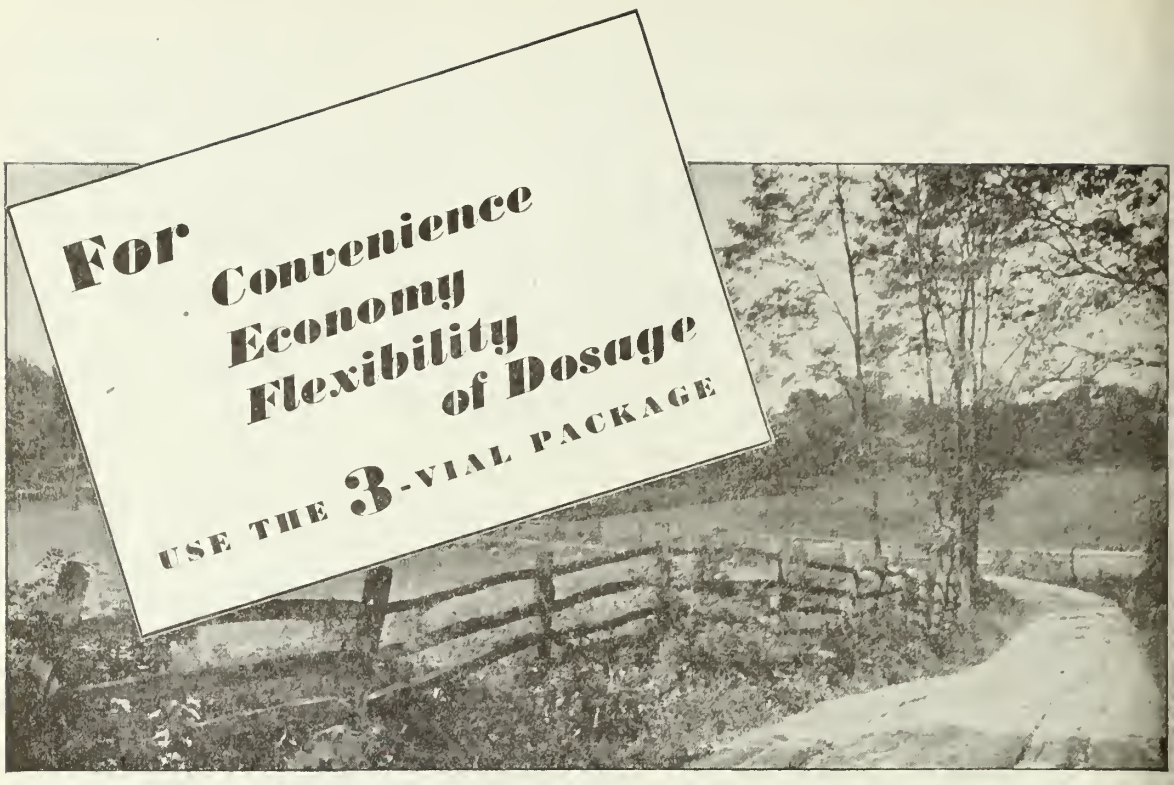
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Ohio State Medical Journal

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Harrison	A. C. Grove, Jewett	W. C. Wallace, Hopedale	3d Wednesday, monthly.
Jefferson	Victor Biddle, Steubenville	John Y. Bevan, Steubenville	Last Thursday, monthly.
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Tuscarawas	C. J. Miller, New Phila.	G. L. Sackett, New Phila.	2d Thursday, monthly.
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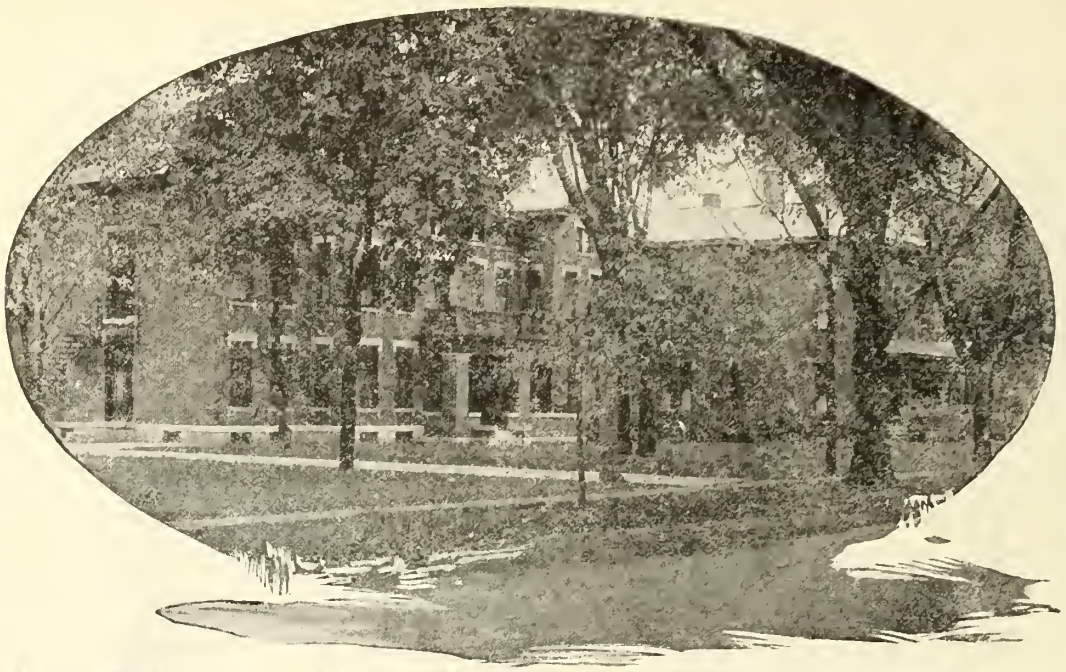
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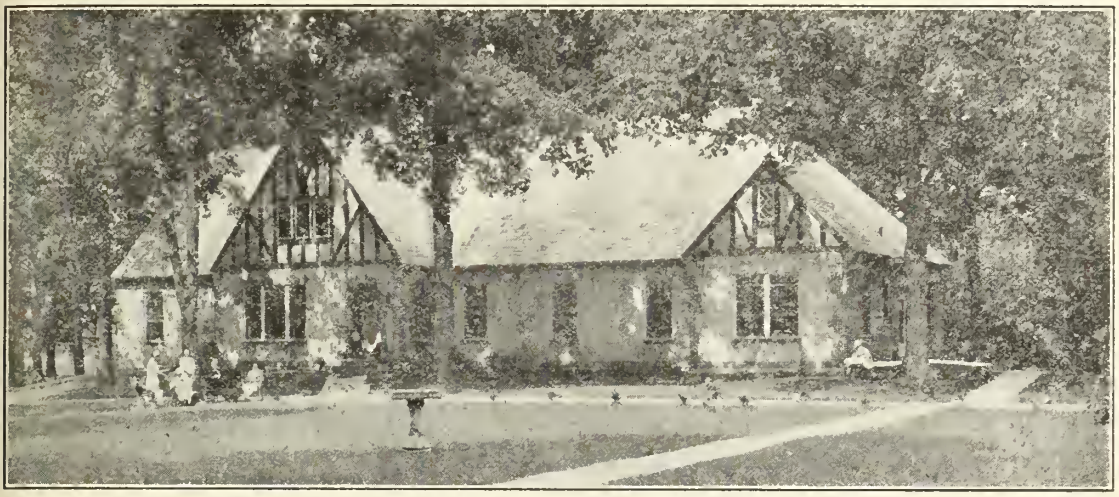
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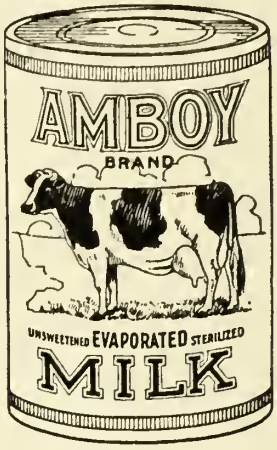
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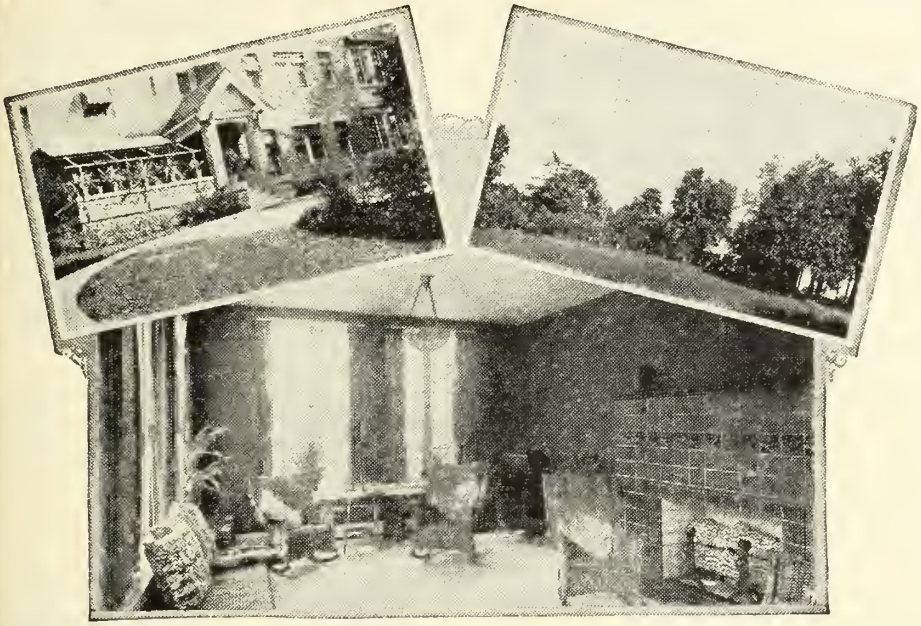
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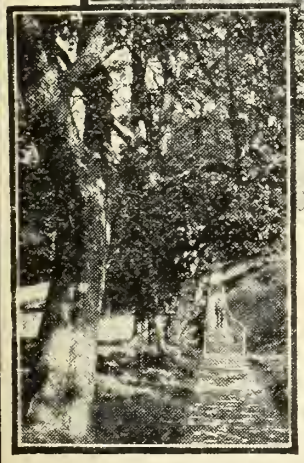
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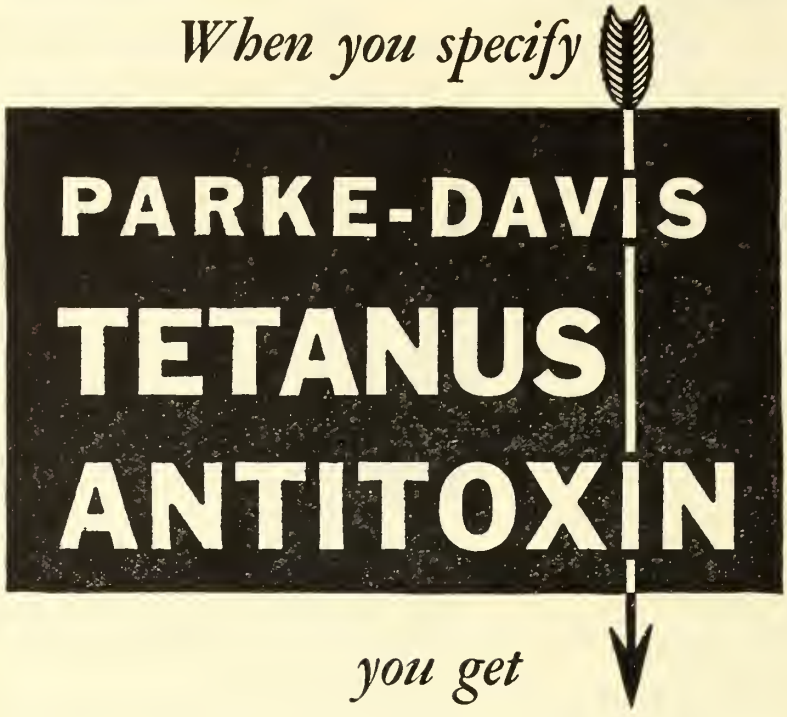
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PUBLIC HEALTH - SOCIAL WELFARE MEDICAL ECONOMICS and ORGANIZATION PROBLEMS

With Editorial Comment by D.K.M.

The Eighty-Sixth Annual meeting of the Ohio State Medical Association, at Dayton, May 3 and 4, held at a time when society is being shaken by social and economic unrest, will undoubtedly be recorded as one of the most important gatherings yet held by the medical professon of Ohio.

Spirit of Service Exemplified in the Annual Meeting

Characterized by a spirit of sincerity, unity and active enthusiasm on the part of the membership, the Dayton meeting demonstrated that the medical profession of Ohio is fully aware of the immensity of its duties and obligations and is determined to continue with those programs which are based on the primary objects of organized medicine—"the promotion of the science and art of medicine and the protection of public health".

The large attendance at the meeting corroborated the significant observation made by Dr. D. C. Houser, Urbana, the retiring president in his presidential address, that "the strength and effectiveness of our organization is made possible by the large number of members who are not officers or on committees but who are willing to give their time and thought for the good of all". Furthermore, this fact was proved when so many physicians were willing to travel many miles, if necessary, to hear the interesting and informative discussions on scientific subjects, and presentations on social and economic questions.

The officers of the various sections and others who had any part in preparation of the scientific program are deserving of much commendation, as are the essayists and discussants who contributed so largely to the success of the gathering.

The business affairs of the State Association were transacted in a laudable manner by the House of Delegates, evidencing the wisdom of the membership generally in the selection of their representatives in that body. There is every reason to believe that the serious and important questions confronting the medical profession will be correctly solved, if at all possible, and the interests of the public, as well as the medical profession, protected with physicians of such high caliber at the helm. A detailed account of the transactions of the House of Delegates is published in this issue of *The Journal*.

Energetic work on the part of the local committees in arranging and carrying out the many details incident to the meeting prepared the stage for a successful gathering and constituted the machinery which kept the two-days program of events operating smoothly and with a minimum of confusion.

The Dayton meeting was in many respects a glowing tribute to Dr. Houser, the retiring president, whose sacrifice of time and effort and whose devotion to the cause of organized medicine and the medical profession, individually and collectively, are unexcelled. Much of the enthusiasm, harmony and spirit of cooperation so much in evidence during the gathering was undoubtedly inspired by the faithful, unselfish and untiring service rendered by him during his presidency. His calm judgment, judicious temperament, sincerity of purpose, courage in meeting important issues, and unswerving desire to carry out the responsibilities of his office for the best interests of the entire medical profession and the public, were of inestimable benefit to medical organization during a difficult period. Dr. Houser's ability as a leader is exemplified by the fact that medical organization has completed another year of outstanding accomplishments and is capably prepared to face the serious problems of the future.

The inauguration of Dr. H. M. Platter, Columbus, as Dr. Houser's successor assures the State Association of a continuation of constructive leadership. For many years Dr. Platter has been a key-man in medical organization in Ohio, rendering constant and unselfish service in many capacities, giving willingly and gladly of his time, splendid judgment and broad experience to the cause of organized medicine. His thorough knowledge of organization, economic, and governmental questions qualifies him to an exceptional degree for the duties of the presidency. Dr. Platter's unfailing belief that the ideals of medicine must be preserved and the Code of Ethics must govern the relationship between physicians and between the profession and the public, should be an inspiration to his colleagues. His modest, sincere manner has won for him a host of friends, both within and outside of the profession. With Dr. Platter at the helm, medical organization in Ohio may be confident of earnest and capable leadership.

By selecting Dr. C. L. Cummer, Cleveland, as president-elect, the House of Delegates followed the established precedent of the State Association that none but the best deserve the honor and responsibilities of the presidency. As Councilor of the Fifth District since 1927, Dr. Cummer has made an enviable record, not only in his services

to the physicians of his own district but to the membership at large. Possessed of marked ability, tireless zeal and a genius for organization, Dr. Cummer always has discharged numerous tasks efficiently, and with an enthusiasm and earnestness which gave assurance that they would be completed effectively and promptly. Dr. Cummer's counsel has been sought by his predecessors, his associates on the Council, and by hundreds among the membership generally on important administrative questions and on other vital problems. His wide acquaintanceship, keen judgment and deep devotion to the purposes and objects of organized medicine equip him remarkably well as a sucessor to those who have been entrusted with, and who have faithfully discharged, the responsibilities of leadership.

A Recent Study of Health Insurance

No doubt some Ohio physicians have read recent reviews or newspaper releases written by the publishers of a report in book form, under the title, "The Way of Health Insurance", of a two-years investigation of compulsory insurance systems in operation in various European countries, made by A. M. Simons, a member of the research staff of the Committee on the Study of Dental Practice of the American Dental Association, and Nathan Sinai, associate professor of public health, University of Michigan.

Simons and Sinai in their 215-page volume have produced an interesting summary of the complicated European social insurance systems.

Perhaps some who have had a chance to read the complete report, and who value it for its information, are ready to take issue with part of the conclusions drawn by the investigators, some of which have the ear-marks of subtle propaganda in favor of compulsory state health insurance, despite the authors' statement in the introduction to the volume that "this is a report of what was learned from these various sources, and not a brief for or against insurance or a defense or attack on any of the parties involved in insurance".

However, regardless of the debatable opinions of Simons and Sinai on certain phases of their study, which, naturally, they have a perfect right to express, the volume contains much information and data which should be helpful to the medical profession of this country in adjusting itself to new and complicated social-economic and political developments. Above all, the report should serve as a warning to the physicians of the United States that they must avoid committing errors of omission which were charged to their professional colleagues abroad in the early development of the now extensive insurance schemes functioning in several important European nations.

One portion of the report which is devoted to the early history of social insurance legislation abroad and its effect on the medical profession is of special significance to the medical profession of this country and should stimulate serious consideration of such problems in the light of present-day events.

Referring to the beginning of the social insurance systems abroad, the authors declare:

'The framers of the earlier systems of legislation seem to have seldom recognized that the medical professions are the essential factors in the treatment of disease. The records of the formation of the insurance systems of the nineteenth century contain only slightest reference to the part played by these professions in the preliminary planning that led to such legislation. Employers, labor unions, insurance societies, jurists and, of course, politicians saw that their special interests were protected. But the medical professions were seldom given even the courtesy of a consultation.

"It is not hard to find the reasons for this attitude toward the professions. Even the physicians, who have always borne the brunt of the battle, because they were historically far ahead of the other branches (many of which were barely coming into existence when the first systems were formed), were poorly organized and apparently ignorant of or indifferent to the social, economic and political changes affecting their profession. They looked with disapproval, not unmixed with contempt, upon those members of their profession who were employed by the voluntary insurance funds. This attitude discredited the society doctors and made their influence negligible. The private practitioner looked back upon the centuries during which individual, personal bargaining had dominated the relations of patient and doctor and felt sure that things would continue forever in the same way—perhaps the only social generalization that is always wrong.

"The medical professions contented themselves with denunciations, criticisms, and even strikes against certain features of insurance. The most careful research has failed to find a single instance of the preparation and proposal of any definite alternative plan by professional organizations during the nineteenth century and the first decade of the twentieth, which is the period when the phases of insurance most obnoxious to the medical professions were being crystallized into institutions. Always the criticism and opposition came too late, after the evil had been established.

"This absence of leadership and effective planning has been bitterly and frequently lamented. Pages could be filled with quotations from recent medical publications expressing regret with the lack of foresight and intelligent activity during the formative stages of sickness insurance.

"The worst result of this policy, or lack of policy, in the early stage of insurance was loss of leadership by the professions in health matters and loss of confidence on the part of a large section of the public. Opponents succeeded in maneuvering the medical profession into a position where it appeared to be merely obstructing the efforts to care for the health of the mass of the working people. * * *

"The outcome of the whole situation was that, when political and economic developments created a demand for new methods in the field of health care, the pattern of the new institutions was determined with very little professional influence."

"* * * If any system of compulsory health insurance is ever established in the United States, it is probable that its administration, unless the

medical professions prepare themselves to assume these duties will be in the hands of those now directing private insurance and social service organizations. The United States has already all the elements essential to a wide system of compulsory health insurance; it needs only the jar of some social crisis to crystalize the solution."

These observations on conditions which existed at the time Germany, Great Britain, France and the others launched their huge social insurance programs should not be ignored by the medical profession of this country. There are important lessons to be learned from the experiences of the foreign medical professions.

Many far-sighted leaders of the medical profession in the United States have, on numerous occasions during the past few years, been most emphatic in warning physicians against assuming an attitude of indifference toward social, economic and political trends which vitally affect medical practice and the relationship between the individual physician and his patient.

Those who have analyzed present-day developments have been frank to admit that a titanic encounter between the medical profession on one hand and forces determined to socialize many of our present institutions is not at all improbable. It has been pointed out that the medical profession must have a clear and thorough understanding of these complicated questions and must be prepared to take the lead in planning or directing any changes in medical and health activities to keep them abreast of social and economic advancement.

Unfortunately, some physicians have been disposed to disregard such advice and warnings. Because of a passive attitude or attitude of indifference on the part of the profession in some communities, physicians there have already been forced to surrender their leadership in medical and health activities to individuals and groups outside of the medical profession, and often they are not even consulted regarding policies and procedure concerning programs over which they should have control.

The serious consequences which may result from such inactivity and indifference can readily be visualized after a study of the experiences of the European medical profession in its long conflict with the gigantic social insurance systems there, a picture of which is presented by the authors of "The Way of Health Insurance".

Regardless of its opinions, collectively or individually, regarding compulsory health insurance and other socialized medical-health-welfare programs, the medical profession of this country dare not be indifferent. It must be prepared to meet those who demand a change in present methods with consructive, logical and conclusive arguments. It must be able to explain the merits of its own proposals and the evils of the unsound proposals advocated by opposing or theoretical groups. It must be united. It must have adequate machinery for carrying on its purpose.

Only by maintaining strong and active medical organization, local, state and national, where the concerted medical viewpoint on such matters can be assembled and leadership over medical and health activities developed, can the medical profession of this country hope to be adequately prepared to defend its rights and assert its demands when, and if, crises like those, which found the medical professions of Europe ununited and unprepared, should arise.

Suggestions To New Graduates

A new crop of physicians presently will have been harvested by the medical schools of the country. Four or five thousand men and women—several hundred of them Ohioans—well-equipped and imbued with enthusiasm, will launch their professional careers, following appropriate ceremonies at their respective universities and colleges.

Doubtless, these neophytes of medicine have been, and are now, pondering numerous perplexing questions relative to the opportunities and responsibilities which confront them in the active practice of medicine. They have discovered that it is not a simple matter, practically over night, to step from the scene of study and preparation into a sphere of labor of a different kind, influenced by complex social and economic factors and subject to the principles of competition and supply and demand.

Where to locate; what professional, social and civic contacts should be formed; how to keep abreast of new knowledge in the field of medicine; how to carry out the ideals of medicine and at the same time provide himself and his family with a comfortable living and savings for old age? These are a few of the questions which each medical graduate-elect undoubtedly is asking. The answers are not arrived at easily.

To quote from an address by Dr. William D. Rowland, professor of ophthalmology in the Boston University School of Medicine, to the senior class of that school, each medical graduate is his "own architect".

He urges every graduate to by all means take advantage of an internship, terming internships as "stepping-stones to private practice" and the chance for early association with "desirable older physicians".

Although he believes location and success are interdependent in many respects, Dr. Rowland is of the opinion that the determining factor is good training, declaring "it may be stated that any well-trained young physician can locate anywhere and make a professional and financial success".

Dr. Rowland points out that while the graduate may be led to seek locations in larger centers, feeling that small communities would mean isolation and insufficient hospital facilities, "it should

not be lost sight of, however, that these smaller centers usually offer opportunities for more ready advances, a less exacting career, and a very satisfactory social life".

"Personal desires and perspectives will help solve the problems of larger cities versus smaller communities as suitable fields for private practice", he declared. A good rule to follow is to locate where you wish to live for there you are more likely to be happy and find conditions which will for you develop a satisfactory professional career and provide adequate financial compensation".

Early contact with members of the profession in the community selected for practice—especially if a small community—is quite essential, Dr. Rowland suggests.

"Learn to know them and in turn be known by them in a straightforward and dignified manner", he said. "Offer any type of aid which you might be able to give these men and make yourself so useful that they may willingly turn to you for various kinds of service which recent graduates, up-to-date in medical knowledge and training and with plenty of time on their hands, can give. Here will be your chance, if right contacts are made and your attitude is that of helpfulness modestly given and a fine ethical sense regulates your efforts."

Without intrusion, the new physician should make himself favorably known in the social and civic life of his community; he should make proper hospital connections and establish friendly relations with official health departments, he advises.

"Use your spare moments to read current medical literature and new books, or, perhaps to review some of the work you covered in medical school days," Dr. Rowland advises. "Study diligently your difficult cases. Seek the counsel of your seniors when confronted with grave or difficult problems—you will be a safer and more successful physician and have greater support from your clientele by doing so."

A part of every physician's time, especially the younger man, should be spent in attending local, state and national medical meetings and hospital staff conferences, he believes.

"Be a good listener, but do not make the mistake of being seen and never heard for medical science would never have grown to its present magnificent status had members of the profession largely taken that attitude", he points out. "Frequent conferences, presentation of papers before societies and contributions to the literature of warranted material is as necessary for the growth of any individual as it is for any organization or the profession at large. People know the value of these efforts to keep abreast of the progressing times. They want up-to-date medical care, and loyalty or friendship cannot compete with this demand."

Proper planning, organization and good business methods are most essential in professional work, he maintains, but "not to the point of making a business of your profession". It must be remembered at all times, Dr. Rowland declared that "there are perhaps no real needs of any patient beneath the dignity of the physician to care for".

In conclusion, Dr. Rowland pointed out that the physician should estimate his achievement by comparing himself with persons of his own age, own advantages, own type of work, own native gifts and own actual opportunities; should never permit himself to become discouraged because much of his work is routine and ordinary; must learn to forget past failures, unkind remarks and what might have been done differently, and strive to live his life so that he shall leave his profession better than he found it.

Queries on Animal Experimentation

Reports from various parts of the state indicate that individuals professing to be antivivisectionists through a national organization bearing that name have started a campaign in Ohio to inspire a revolt of the public against animal experimentation.

A considerable amount of literature on the subject has been distributed. Also, some of the ringleaders in the campaign have been successful in having their propaganda published in the daily press, either through interviews or letters appearing in the public forum conducted by most newspapers.

A large portion of the propaganda thus disseminated consists of lengthy statements in which scientific literature has been misquoted, partially quoted or misinterpreted.

Not being content to bolster their cause by distorting scientific articles to suit their purpose, the antivivisection propagandists are attempting to put the medical profession in a compromising and false position by soliciting information from individual physicians on the question of animal experimentation and related subjects. Naturally, the questionnaire distributed by them to physicians is shrewdly and subtly worded, making it possible for the foes of scientific medical research to interpret the replies as being favorable to their destructive intent.

It is to be hoped that Ohio physicians who have received deceptive questionnaires of this kind have ignored them and will continue to do so, on the grounds that their source is, to say the least, questionable.

As a matter of fact, it would appear advisable for every physician to be extremely cautious about replying to questioning types of communications from organizations with which he is not familiar. Before a physician asserts his opinions and signs his name to inquiries he should fully inform himself concerning the standing and reputation of the individual or organization seeking the information and the use to be made of the information obtained.

In other words, the physician should investigate just as thoroughly in matters involving his professional and scientific knowledge and beliefs as in financial and commercial transactions.

Our Objective and Obligations ≠≠≠ Observations on Medical Organization

(Annual Address of the Retiring President)

D. C. HOUSER, M.D., Urbana

It is a constitutional requirement of the Ohio State Medical Association for the President to deliver an annual address. Although there is no provision in the Constitution which indicates or designates the theme or subject of the President's address, it is generally understood that it shall be a short resume of the past year's work, together with some observations which he may have made during the year, and any suggestions which he may care to offer. It is also entirely proper and permissible for him to discuss, in his address, the status of the medical profession in the state and make suggestions of a constructive nature, if deemed advisable.

With a profound respect for our farsighted predecessors in medicine who established such a firm and permanent foundation for our organized efforts eight and a half decades ago here in Ohio, I assumed my duties as President of our State Association a year ago.

Mindful of the honor conferred upon me by elevation to the presidency, I was sobered by reflection upon the immensity of my duties and obligations. In expressing appreciation for your confidence and support at that time, I now extend to you my gratitude for your splendid cooperation during the organization year which comes to an end with our annual meeting.

In a serious effort to carry forward the objects of our organization to the end that our chain of activities and accomplishments might be unbroken, and, if possible, strengthened, I have freely and gladly given some time each day and many whole days each month, to the multiple problems which have come, inevitably, to an organization of such magnitude and importance as ours.

Having visited practically every section of the state in connection with the affairs of our Association, and having attended many county and district meetings of medical societies during the year, I will endeavor to summarize certain comments and recommendations based on my observations.

In order to measure our common efforts, a reminder of our constitutional purposes is proper. Our Ohio State Medical Association has for its primary object "promotion of the science and art of medicine, and the protection of public health". More in detail, our Association is intended "to federate and bring into one compact organization the entire medical profession of the State of Ohio, and to unite with similar organizations in other states to form the American Medical Association; to extend medical knowledge; to elevate the standard of medical education; to encourage enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; to safeguard and foster their material interests; and to enlighten and direct public opinion to the great problems of medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public in the prevention and cure of disease, and in prolonging and adding comfort to life".

THE EXTENT OF OUR CALLING

Medicine, more than ever before, is a career of public responsibility. The service rendered by physicians infiltrates with its influence the destinies of individuals and families, and in the aggregate, the destinies of communities and the nation. A great many of the innumerable social welfare movements and the increasing functions of government in this field, directly impinge on medical practice.

It is not only important, therefore, but also vital, that physicians, being best informed on welfare-health procedures, take a direct interest in and a guiding influence over such matters.

At the present time of extreme unrest, agitators, theorists and reformers flourish. They propagandize for a new social and political structure. Artificial and temporary panaceas are brought forward to correct social and economic imbalances that would add new governmental functions, greater centralization, more bureaus and departments, new services to supersede local responsibility, individual initiative and enterprise. Subsidies, socialism and doles are advocated and supported.

One-fifth of the national income now goes to support government in this country. Government employees, federal, state and local, are in the ratio of one to four of others gainfully employed. The national income has increased 100 per cent in the past twenty years, while government expenses have increased almost 450 per cent. Public social service in England, Scotland and Wales, with a population of 44,000,000, annually reaps the staggering sum of 400,000,000 pounds, showing what may happen in this country if the present trend is followed. Under a perverted interpretation of the general welfare clause of the Constitution there has been a multiplication of administrative bureaus and governmental functions. With the emotional appeal for "mother-child legislation",

Delivered at the 86th Annual Meeting of the Ohio State Medical Association Dayton, Dayton-Biltmore Hotel, Tuesday evening, May 3, 1932.

fantastic theories in government are promoted, while at present, in Washington, there are no fewer than five different federal agencies concerned with health, education or labor of children.

The federal Constitution and the governmental structure itself is threatened today by two elements of society differing not in their aims, but in agreement in their desire for a strongly centralized paternalism. One element is composed of Socialists and Communists, frankly hostile to the dual system of our government under which power not granted to the nation is reserved to the states. It is aided and abetted by bureaucrats determined on increasing the power and scope of the bureaus to which they are attached. The other element composed of those desiring social reforms, many of them in themselves worthy, are impatient at the delay involved in dealing with the forty-eight states in their zeal for reform itself. Those who make up this element disregard the destructive consequences of their methods upon our American institutions.

MULTIPLE ORGANIZATION IN THE HEALTH-WELFARE FIELD

As a counterpart of its agencies already engrafted into government we find innumerable unofficial organizations and movements tending toward socialization and an increase in personal service, including medical service to be furnished individuals or favored groups. A casual study of the situation gives reason for serious doubt as to the real good some of the so-called voluntary health-welfare organizations are doing beyond providing their officers with a definite income and the production of propaganda tending to interfere with the orderly procedure of government itself. That type of philanthropy, which makes such organizations possible, would do well to scrutinize more closely the purposes behind requests for contributions, and the ultimate disposition of their benefactions.

And so, as aptly described by Oliver Wendell Holmes, poet and physician, "the profession which for more than two thousand years has devoted itself to the pursuit of the best earthly interest of mankind, always assailed from without by such as are ignorant of its infinite perplexities and labors, waging an unequal contest with the hundred-armed monster that walks at noon and sleeps not at night, but toils on, nevertheless, not for itself or for the present moment, but for the race and future."

THE ECONOMICS OF SICKNESS

Much is being said and written about the unequal distribution and the unbearable burden of sickness, especially on the people frequently designated as the "middle class." It is not only unfair but unwise in a consideration of the cost of illness to ignore the fundamentals of economics generaliy, including problems of steady employment, thrift, self-responsibility, adequate wages, voluntary commercial insurance as opposed to compulsory state medicine, balanced budgets, proportionate spending, with due consideration for the necessities and comforts as contrasted with needless luxuries, and similar factors.

It is said that approximately three per cent of the income of this country is spent because of illness. Much less than one-half of one per cent goes to make up the income of the medical profession. Much of it goes to allied professions, self-medication, cultists and institutional care. It may be stated as an economic fact that the legitimate cost of sickness is not excessive, but the distribution of this cost, or its unwise expenditure, may be the chief cause of hardship. Practically all sickness is unexpected, and too few make any provision for it in their financial arrangements. In spite of these facts, a proportion of the public declares a medical economic crisis to exist and demands relief from the profession itself or through legislation, forcing radical changes in medical practice.

Thus not only government agencies, but private philanthropists are encroaching on the practice of medicine. The medical profession always has and always will take good care of the worthy poor, but free clinics and free hospitals are growing like mushrooms until they have far outdistanced the needs of the poor. These agencies are extending their free medical service to include a large class of patients who are able to pay. Many social and welfare workers are encouraging this practice and are indiscriminately referring patients to free institutions without regard to their financial status. About nine million patients will be treated this year, in America, in free clinics. Philanthropic and charity organizations vie with each other in establishing free clinics until there is needless overlapping and duplication, and in many clinics the work is perfunctory and falls below the standards of modern medicine.

There is a rapidly growing tendency for philanthropy and charity to exploit the physician in these undertakings. Large sums of money are spent on buildings, administration and a well-paid personnel. The doctor, *whose service is the commodity that these organizations offer*, works without compensation and is usually denied any voice in how or to whom his service is given. It must be remembered that *the doctor* is the only *vital part of these organizations* and that they only exist to distribute the free service which they exact from him.

The medical profession is not responsible for either poverty or sickness. As a matter of fact it leads all professions and groups of citizens in the prevention of disease, and this in spite of the other fact that the members of the medical profession gain their incomes from the care of people suffering from disease. Likewise, the profession is no more responsible for the care of the indigent sick than is any other member of society.

No other class or profession can be employed by these charity institutions without pay. Society as a whole is responsible for the entire care of the sick poor and not just for food and shelter. It has no right to exact service from the doctor without compensation.

It will be remembered by most of you that the House of Delegates several years ago, in adopting the report of the Medical Economics Committee, summarized the attitude of medical organization toward "state medicine" and "socialized medicine" as follows: "That any plan or system which affects the medical profession detrimentally will inevitably be detrimental to the public as well. Any plan, system, or activity which tends to destroy or lessen scientific research, individual initiative and ambition, adequate remuneration for effort and ability, scientific independence, reasonable competition, personal responsibility; which would lower the standards of medical education or inculcate unsound ideas in the public mind toward scientific medicine, are wrong, unwise, impractical and will inevitably be doubly costly to the public."

PUBLIC HEALTH AND MEDICAL ORGANIZATION

In spite of the fact that the medical profession conceived and has always advocated and supported practical measures for public health, and in spite of the fact that medical principles must underlie the effective application of public health administration, some individuals and organizations interested in public health problems and even a few members of the medical profession, have conceived the erroneous impression that medical practice is something opposed to public health, or at least something differing widely from it.

It is apparent, however, that the very term "public health" and its practice or administration is difficult to define to the satisfaction of all. In the minds and words of a few ardent but misguided proponents it is becoming increasingly evident that public health is expected to include all medical effort and service, both preventive and curative. The medical and quasi-medical care of the child, the guidance of the adolescent, the treatment of the unfortunate devotee of Venus, the correction of defects, both physical and mental, education and training in dietetics, prevention and treatment of the diseases of middle age and old age—all these, and many other more obvious matters, are included, according to some of the more enthusiastic agencies of public health, in the scope of public health.

However, public health is and should continue to be much more rigidly limited. Public health is, in its essence, the promotion by the public at large, through designated agents and agencies, of health for the public at large, but not for the individual as an individual. Based upon this definition, public health should have but one concern, and that is the protection of the public's environment. Such environmental protection has three subdivisions. These are (a) sanitation, (b) communicable disease control, (c) public information and education.

As pointed out in a splendid report on this subject by a special committee in another state, sanitation is without argument the task of public health. The control of water and food supplies, to the end that they be clean, wholesome, and free from disease-producing micro-organisms, is a work, which, being for the public at large, should be done by the public. It is obviously impossible for an individual to protect his own water supply, or milk supply, forced as he is by law or the exigencies of modern communal life to partake of the common supply. It is obviously impossible for him to protect himself against the bites of disease-bearing insects and the like by destroying their breeding places, when their breeding places are situated on land over which he has no ownership or control.

Likewise, communicable diseases must of necessity be a matter for public concern. The presence of a disease which can be communicated from person to person forces upon the public at large the duty of preventing such communication. A case of scarlet fever is not an individualistic matter. Its presence, due to its ready communicability through contagion, renders it a threat to the entire public. The suffering of a disease, the probability of personal sequelae, and the possibility of personal death, are individualistic matters, to be coped with as such; but the element of contagion, the danger of transference of the disease through direct or indirect contact, is a matter for the public to prevent, through the agency of a quarantine by its public health authorities.

These are the prime duties of public health: sanitation and the communicable disease control through quarantine. However, due to the development of bacteriological knowledge, to the control of communicable disease through *quarantine* there must be added its control through *immunization*. The protection of an individual against a communicable disease through immunization is an individualistic matter to the person immunized, but it gains also a public interest, because the individual so immunized, not being likely to contract the disease, will not communicate it to the public at large. It is greatly to the advantage of the public that its members be immunized against smallpox, for example, since quarantine can be imposed only after the recognition of the disease, while contagion may take place in the preliminary period before the disease has frankly manifested itself.

POLICIES ARE CLEARLY DEFINED

That committee also found that some official health departments, state, county, and local, together with affiliated and unaffiliated, unofficial

health organizations, engage in activities far removed from a properly defined public health. Thus, in addition to sanitation and communicable disease control, we find them in unrelated fields, working and continually expanding, with their expansion often at the expense of more intensive work in the two divisions rightly theirs. We find, often, health departments putting great effort into pre-natal care, a matter entirely individualistic (unless we regard the unborn child as the ward of the state) while at the same time very little attention is paid to obvious sanitary lapses in the environment of the women receiving the pre-natal care. It is disturbing to note the time and effort given by some health leaders to the strictly individual problem of the increase of heart disease, with the installation of heart clinics, and the issuing of large amounts of publicity, and find at the same time in the same locality no rigidly conducted fecal examinations of food handlers for the organisms of enteric disease. To put the matter plainly, public health at the present time in some communities is taking on new jobs before it has satisfactorily completed the old.

It seems to me that our policies are so clear and well defined on these matters that no repetition should be necessary. However, in view of questions raised recently by a few of our members as to the proper and respective field of medical organization and public health, it may be well to summarize those major principles which have been established by action of the House of Delegates. Being preventive and educational, the function of public health is not the treatment of disease, except in (a) institutional care of the wards of the state, delinquent, diseased and defective; (b) the treatment of those whose treatment is essential to prevention, and (c) the inspection, recognition and recommendation for correction of the common defects of school children, as a primary feature of health education.

Any public clinic, conducted by health agencies, should be restricted to educational purposes only, and should be held under the direction and supervision, or with the official approval of, the local county medical society or academy of medicine.

Immunization as well as all personal medical services, preventive as well as curative, should, when possible, be considered a part of private medical practice. The examination of patients and diagnosing of disease or impairment is a part of medical practice. Public health agencies, official and unofficial, should not "practice medicine."

I am quite sure I voice the opinion of the present State Director of Health on the various health matters which I have mentioned. He is doing much toward correcting the erroneous belief that organized medicine and public health are two separate organizations.

OUR COUNTY UNITS

Under our plan of organization, the county unit is the basis. It is especially important that every county medical society, or academy of medicine, have the greatest possible degree of freedom both in its constitutional set-up and its activities, to meet local conditions. There are, of course, a few necessary and uniform fundamentals, especially those having to do with the attachment of the units to the State Association, which, in effect, is the federation of the county units themselves.

It is needless to elaborate on the necessity of each society selecting officers and committees with initiative, vision and willingness to sacrifice the time from their practice necessary for the promotion of the affairs of the society. The primary purpose of organized medicine, "the advancement of scientific knowledge and the promotion of public health", must not be forgotten. For this reason, interesting scientific programs are necessary. It has been my observation that ordinarily the smaller county societies have a greater proportion of their membership in attendance at meetings than do the larger societies. This may be due somewhat to the greater number of medical meetings, in the larger centers, of special groups or sections of academies of medicine, hospital staff meetings, etc. It is apparent that there are really too many medical meetings in some communities, tending to detract from the county society itself, which, after all, is and must continue to be the fundamentally important medical group. So-called "one-man" societies are rarely successful for any length of time. The permanency of organization and its value to the membership will depend on the greatest possible proportion of interest and activity among the membership generally.

Occasional dinner meetings, social or semi-social functions in connection with medical meetings, occasional joint meetings with allied professions, or even lay groups interested in common problems, social and governmental, as well as scientific, are desirable.

DISTRICT AND GROUP ORGANIZATIONS

While the county units are more or less uniform, at least in the fundamentals of organization, a variety of group affiliations have developed in some sections of the state, wherein several adjoining county societies hold joint meetings. There have been some suggestions and requests for realignments in the Councilor Districts, and perhaps eventually, thought should be given to the question of redistricting with a possible increase in the number of districts and a consequent increase in the number of councilors.

In spite of the fact that our State Organization is intended to be and actually is as democratic as possible, there have been occasional comments to the effect that certain groups or cliques dominate

its policies and activities. There have been implications that the specialists are in the ascendancy to the detriment of the members in general practice. There have been allegations to the effect that there is an alignment or a difference in viewpoint and policy between the metropolitan and the rural section.

During my year as President, the several preceding years as a member of the Council, and the approximate twenty-five years that I served in the House of Delegates, I have never seen an indication where any official policy or procedure ignored the best interests nor the well-considered desires of the men in general practice in the rural sections or cities. Our policies, our programs and our procedures have uniformly given primary consideration to the general practitioner. This I believe to be correct, but ill-considered or unfounded criticism alleging that the situation is different than it really is, cannot help but be detrimental to the unity and harmony of our Association, and cannot be condoned.

In the matter of representation in the House of Delegates, for example, the metropolitan districts have far fewer delegates in proportion to the membership than the rural counties, and if our organization is really as democratic as we intend, each member who shows an earnest and constructive interest, and regardless of the varying viewpoints, should be given equal consideration with every other member. If this be true, then the majority of our members are in communities which may be defined as cities, but I cannot see how their problems or their viewpoints differ from those of their colleagues in the rural sections, unless, perchance, their problems of a social economic nature are more involved on account of free clinics, group practice, hospital organizations and similar factors.

Regardless of developments, and especially in case medicine finds itself harassed by further complications, socialization and governmental dominations, we will need unity and strength to meet those situations and to secure and safeguard for us and for the public good, an independent, self-respecting, economically secure medical profession.

Because of the fundamental nature of our calling, its value and need to the permanence, health, happiness and security of society, we are justified in a hopefulness apparently contradicted by present-day perplexities.

With due humility, however, we may feel with Isaac Newton, "like a little child that has been picking up a few pebbles on the shore of the great ocean of undiscovered truth."

NEED OF STRONG STATE-WIDE ORGANIZATION

Obviously and regardless of the fact that the basis of all successful medical organization is the aggregate of the county units, its units separately cannot function on problems of a state-wide nature. Therefore, a strong active organization is necessary, with an efficient headquarter's staff with constant contacts with all governmental departments, bureaus and boards, and with all statewide allied professions and with lay groups having to do in any way with public health and medical service. Under the supervision of the Council and the various standing and special committees of the Association, our efforts must be co-ordinated and made consecutive through our permanent state headquarters. If time permitted, I would like to analyze and commend in detail our various State Association committees which have given unselfishly of their time and thought for the good of our profession as a whole. Some of their activities and accomplishments are reflected in their recent annual reports published in the current May issue of our *State Medical Journal*, and should be read by every member. At this point I wish to urge the members to keep a permanent file of their *Journals*, which constitute a consecutive record on many subjects of direct interest and value—scientific, economic, social and governmental. Frequent references are made from time to time to articles published previously in *The Journal*, including interpretations of laws or court decisions pertaining to medical practice and public health administration.

The strength and effectiveness of our organization is made possible by the large number of members who are not officers or on committees and who are so willing to give their time and thought for the good of all.

There never has been a time, at least during the lives of any of us now in practice, when we were confronted by as many complex problems—economic, social, governmental and legislative, affecting medical practice and public health. Sudden changes are imminent in our entire social and governmental structure.

Medicine by its very nature, if it fulfills its function, must be a structure of cooperations, complex as they are. In the words of Professor Hans Zinsser, "It is a great tree of many branches, which takes its roots in the basic sciences and spreads into innumerable arms of specialization. To keep it green and growing the sap must be kept running from the roots to the leaves, and this can be accomplished only by the constant coordination of activities that in method, material and the very nature of the talents demanded would seem utterly unrelated."

For my successor, for the Council and for other officers and committees I bespeak the same measure of splendid cooperation from the membership which has been, so generously and graciously, extended to me.



H. M. PLATTER, M.D., COLUMBUS

President of the Ohio State Medical Association for the year 1932-1933

The Doctor, The Organization and The Code

Inaugural Address of the Incoming President

H. M. PLATTER, M.D., Columbus

The historian, Adams, in his "Epic of America" discusses the traits of our early settlers and finds the following predominant: Intolerance, love of adventure, excesses of various kinds, acquisitiveness, love of individual liberty amounting to lawlessness, courage and industry. If we consider these traits to have fused to make the American of today, abundance of evidence is at hand to explain our phenomenal advances as well as our reverses. As we meet, we are passing through a period in which our people have indulged in all manner of excesses. Stimulated by siren voices to believe a new era was at hand during which each individual might become a Croesus, an era in which poverty was to be banished, the idealistic part of us sought to bring about a heaven on earth. It does not take much flight of the imagination to carry the thought of some of our recent economists to the point where we could envision our streets to be paved with gold, though our lack of cultivation of a love of music, perhaps, would not have fitted us for membership in the choir. During this period of affluence, the idealist set about to put our house in order by instituting investigations and surveys to increase our efficiency and to prepare us for the new life. Always, however, this efficiency was builded on the dollar. With money, all things were possible. There has come a rude awakening, the prophecies of banishment of poverty, idleness, sickness, disease and death have failed to materialize. Seemingly, history repeats itself, for as in Biblical times after the worship of the golden calf a similar period of remorse and retribution was visited upon us.

As our early settlers overcame one frontier after another and finally created our great nation, there went with them in their undertakings men of medicine. No doubt, they, too, possessed, in part, most of the traits before mentioned, but during their education they were constantly adjured to hold fast to the teachings of the code laid down by Hippocrates and when we read in the early history of Ohio that within eight years after admission to statehood our medical forefathers agitated and secured the passage of a law "to regulate the practice of physic and surgery because of its interest to society and to give encouragement for its promotion and correction of its abuses", it would seem that, at least, our profession began at an early date to give evidence of realization of the responsibilities and obligations resting upon it.

You know that these early acts provided for examination and licensure by district medical societies. Further, that at first most of the practitioners took up their work after studying under a preceptor. The statistics show that in the early part of the last century but 10 per cent of the practitioners of medicine in this country were graduates of a medical school. With some but slight changes these early laws continued on our statute books until 1868, the district medical societies performing the functions of boards of licensure and then for a period the following requirements were exacted: A certificate of qualification from a state or county medical society; or, graduation at some school of medicine either in the United States or some foreign country after attending two full courses of instruction; and, from 1885 to 1896, graduation from a *reputable* school of medicine. Then followed increased preliminary requirements and lengthening of the professional course.

I mention these matters in detail to show that the profession itself at all times has stimulated better medical education, and to call to your mind the present-day requirement of at least two collegiate years and four years in an *accredited* school and the passing of an examination, to refute the oft-repeated statement in magazines or periodicals that "the *quality* of the service we render does not compare favorably with that of earlier days".

As you read the history of medical education in America, you must be convinced that the profession has been true to its ideals. A very great stimulus to this advance has been our state medical organization now meeting in 86th annual session. From its membership came the leaders who have constantly advanced the cause of better preparation and better work. And, as our retiring President sums up the achievements of his year and as you read the reports of the various committees, I am sure you will renew your belief that the practice of medicine as conducted in America and medical education, too, as exemplified in our accredited medical schools is making a contribution greater than that of any other profession or organization for humanity.

It is to be admitted that, perhaps, some of our members have elected to worship Mammon and that some abuses may have crept in. These, however, have been individual and the organization itself is not to be held accountable. A former Governor of our State declared guilt to be "personal". This observation seems to meet the present charges filed against us at times in newspapers and periodicals. They, in no wise, affect the integrity and fair dealing of medical organizations and of the profession as a whole, unless it

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can be charged that in some certain localities a condition of inertia exists in the county medical society.

In a sense, medical men are still frontiersmen. At the bedside, in the operating room and in the laboratory they are individually attacking the frontier of disease and suffering. Many notable victories have been won and the future bids fair to record many more. These accomplishments are the result of individual and conscientious effort and stand as monuments of contribtuions to the public good. Why a profession with such a record and such a membership should be deemed incapable of managing its own affairs seems hard or impossible to explain. Certainly, state medicine will rob us of initiative and halt our progress.

There is, however, an obligation resting upon us which we can no longer evade. Our code requires us to be members of medical societies. Mere membership is not enough. It further provides that each member should contribute of his time, energy and means in order that these societies may represent the ideals of the profession. Further, each member should become acquainted with the policies of our state and national associations in order that his conduct may reflect credit upon his county society and each county medical society should be organized to carry out the policies of our association in conformity with the modernized precepts of the code. These include an interest in civic affairs in the name of the county society and organization to extend its usefulness into the field of preventive, as well as curative medicine as is now demanded by the public. We can no longer evade the obligation to render a service in periodic health examinations, immunization against disease and the other practices within the domain of prevention. In times of distress or crisis the medical profession has never been found wanting. I believe the practitioner will live up to expectations and perform his services willingly—always without pauperization of the individual—and that as we emerge from the trying period through which we are now passing, he will be recognized as a more influential member of his community. I have an abiding faith in the membership but insist that ethical lapses should not be tolerated but promptly considered by each county society.

Additional laws to correct apparent abuses are unnecessary. They serve as a "smoke screen" or a means of placing on other shoulders a disagreeable duty which should be undertaken by the county society.

It is imperative that leadership shall be developed in each county society to meet our obligations to the public and to each other. Modern medical practice has developed new methods and procedures. Many non-medical assistants aid the physician in hospitals, laboratories, public health activities, school and industrial medicine, insurance practice, child welfare and a variety of activities dealing with health. Local medical organizations must assume the leadership in these activities. Upon the organization rests this responsibility. Medical writers are beginning to regard medicine as a social as well as a biological science. Indeed, there seems to be a like change in the fundamentals of other professions, industry and commerce. Our conceptions are being broadened by social and economic factors and medical leadership must be ever alert to meet the changing conditions.

The historian has repeatedly called attention to the fact that America was the "land of freedom, of equality and of opportunity". We have boasted of our absence of caste and the opportunity offered each and every man to advance according to his ability. It seems a similar dream or hope has ever lived in the mind of the medical practitioner and to achieve its greatest results, medicine must remain an individual activity limited only in its practice and performance by the provisions of our code.

It is generally conceded that the world is filled with troubles and that politics, economics and dictatorships have not succeeded in bringing order out of chaos. Our troubles (to us major ones) are minor in comparison. All probably arise from the same cause, namely, a dismissal or disregard of ethics. In a discussion of the general problem, Dr. Charles A. Beard, Social Historian, writes in *Scribner's* December, 1931:

> "Politics alone is helpless, because as an art it relies on opinion. Economics separated from politics is only half a subject to start with and is in such a state of chaos that it no longer boasts of being a science. Natural science is powerless in the human domain because it is of necessity neutral, it can not say whether chemistry should be used for killing or for healing. Its victories have come from its neutrality and when it departs from neutrality, it ceases to be science and becomes ethics, prejudice or superstition. That is why millions spent for research in sociology, unguided by a dominant ethical purpose, will never bring us to the center of things. When knowledge and purpose are what we need, government by consulting uninformed opinion is only a little better than consulting the stars or the entrails of birds."

He contends that the supreme cause of confusion is a contempt for ethics and believes the ethical reconciliation, when formulated for the world of business, will recur to first principles and be as the "Sermon on the Mount" with the good life as its center, and that it will distinguish between money getting and wealth creating, between honor and expediency, and between obligation and right; that recognition will be given to the material because men can not live without

bread, but, recognition will also be given to the spiritual. And, concludes his observation with the statement that "The ethical reconciliation will return after 2,000 years to the beginning made by Aristotle". As applied to us, it would seem that our reconciliation will return after a lapse of years to the philosophy of Hippocrates and a rededication of ourselves to service to humanity. A profession rich in its traditions and splendid in its achievements but still dissatisfied with its results will continue to advance so long as it is true to its ideals. 185 E. STATE ST.

Brain Trauma

(Mechanism from the Pathological Standpoint*)

N. W. WINKELMAN, M.D., Philadelphia, Pennsylvania

WHEN blood enters the subarachnoid space, either by direct injection through a syringe, as can be done in the experimental animal, or as the result of trauma, there occurs a reaction which gives all the signs and symptoms of a severe meningeal irritation. A classical example of an uncomplicated subarachnoid bleeding is the so-called spontaneous subarachnoid hemorrhage. This condition that comes on without trauma, occurs suddenly in apparently healthy individuals and produces intense headache, vomiting, fever, neck rigidity, stupor, and may lead to death. It therefore gives evidence that the patient's own blood in the spinal fluid system acts as foreign substance. It therefore follows that the signs and symptoms that one ordinarily meets with in even mild brain trauma may be intensified if bleeding occurs into the cerebro-spinal fluid reservoir.

When the brain of a patient who had died from a subarachnoid hemorrhage is examined postmortem, one is able to trace the course of the blood from the base where the hemorrhage usually takes place. In cases of this sort, one can follow the pathway by which the blood travels and can deduct that this is the pathway of flow of the cerebrospinal fluid. In tracing this pathway one notes that the blood reaches the interpeduncular space and then spreads out latterally in the fissures of Sylvius until it reaches the cortex and proceeds up over the cortex towards the superior longitudinal sinus. This is also the route taken by air in the ordinary encephalographic study. It becomes obvious that both the blood and the air take the "beaten path" of the cerebro-spinal fluid.

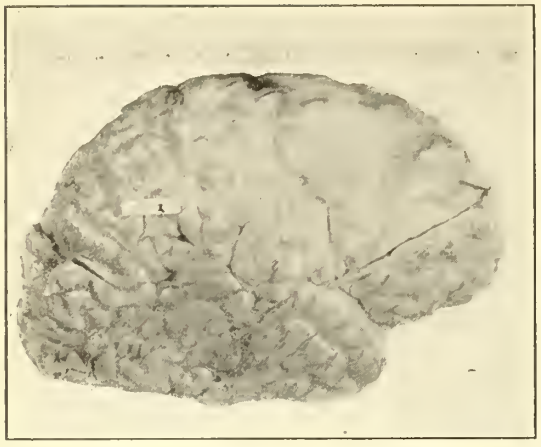
For our purpose here in the consideration of the brain trauma, the circulation of the cerebrospinal fluid can be dismissed with but few words. It is generally believed that the spinal fluid is a dialysate and is the result of filtration through the choroid plexus plus the admixture of the katabolic products from the brain substance itself which pours into the subarachnoid space through the perivascular channels. The formation from the choroid plexus takes place in the ventricular system, the fluid making its way out of the ventricles through the foramen around the base of the brain in relation to the medulla oblongata. From this point it proceeds anteriorly along the base and then up over the cortex, towards the superior longitudinal sinus. There is still considerable controversy as to the means by which the fluid leaves the subarachnoid space. It will suffice here to state that it is our opinion, based on the work of Key and Retzius, and Weed, and our own work, that the cerebro-spinal fluid filters through the pacchionian bodies into the superior longitudinal sinus. In farticulate matter such as blood or pus within the subarachnoid space eventually act as coffee-grounds would in a sink in preventing the free filtration of the fluid into the venus system.

As the result of irritation of the subarachnoid structures including the pacchionian bodies there results a fibrosis of the involved tissues. Such fibrous pacchionian bodies we have seen in cases of old traumatic cases and there is no doubt in our minds that as the result of this fibrosis there occurs a damming back of fluid over the cortex of the brain in the area of fluid flow. Such damming back of fluid would exert its pressure directly over the area in which it lies. If this theoretical consideration is correct, we should get an atrophy that is of the pressure type in the fronto-motor-parietal area and not in the temporal or occipital lobes. This is exactly what is found in the ordinary old traumatic case and in the usual case of senile deterioration, aside from arteriosclerosis where a gradual fibrosis of the meninges and its filters has occurred. As can be seen from the accompanying illustration the area of involvement of the meninges, as shown by the intense opacity, is limited to a triangular field over the fronto-motor-parietal area. This does not occur by accident and in the examination of hundreds of brains from various pathological conditions, the limitations of the atrophy to this field, in what

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So-called arachnoiditis. Intense opacity in the fluid field (frontal-parietal area).

we have now called the fluid field, is rather sharp.

In meningitis where the inflammatory process starts at the base, one can usually see the path of travel of the pyogenic material in the fluid field, before there is a diffuse involvement of the entire brain. From the fact that the filters are blocked, as the result of pus in the spinal fluid, it has been our policy to utilize this knowledge in the clinical application. We therefore make it a practice to drain off the pus as frequently as possible through a spinal puncture needle, because of the possibility of relieving these filters of undue blockage in a case of meningitis. Our efforts here are, of course, not usually successful, because of the virulence of the organisms, but with blood in the spinal fluid one can save the patient a great deal of the after-results, such as dizziness and headache, by thoroughly draining the blood from the subarachnoid space.

These principles apply not only to the traumata of children and adults, but apply with equal force, to new-born infants, where birth trauma has been sustained. It is well known that bleeding occurs in the subarachnoid space in the new-born infants in nearly 15 per cent of cases. Such a startling disclosure was shown by the work of Sharpe of New York, who routinely did spinal puncture on all new-born infants. If this occurs, as it probably does in other clinics of the country, the explanation for some of the post-traumatic cases that we see has a solution. Even a small amount of blood in the spinal fluid may have the effect of provoking a reaction in the infant's brain sufficient to produce in later life a convulsive state. The therapeusis of cases of this sort should be the same as that in the adult. Spinal fluid drainage should be done until the fluid is relatively clear. Encephalographic studies in early infancy have taught us that secondary changes in the brain can occur with remarkable rapidity and in the course of but a few months a permanent change will take place.

SUMMARY

1. Blood in the subarachnoid space acts as an irritant and produces the clinical picture of a meningeal inflammation, and pathologically the so-called aseptic meningitis.

2. It is therefore necessary to remove as much blood as possible from the subarachnoid space by spinal drainage, even five and six times a day if necessary, in order to prevent the reaction in the meninges that will surely occur if the blood is allowed to remain for any length of time.

3. In case of head trauma when the spinal fluid is bloody, spinal drainage is one of the means of therapeusis.

4. The secondary results of subarachnoid bleeding is blockage to the spinal fluid out-flow through the pacchionian filters and the damming back of the fluid over the vertex. A continuation of this mechanism with the result in a type of atrophy of the convolutions that we speak of as pressure atrophy and is similar in all respects to the atrophy of the skin that one sees under a ring on a finger. This pressure atrophy of the brain is the result of the close fitting fluid cast and the amount of atrophy is dependent on the degree of hindrance of the filtration of the spinal fluid, producing back-pressure.

5. The after-results of head trauma, such as a change in character, mental deterioration, head trauma, and dizziness are explainable on the basis of gross organic changes in the brain rather than the results of a neurosis. It has been shown rather conclusively that a so-called traumatic neurosis may have an organic basis that can be visualized by encephalographic study. It therefore behooves us to be cautious in making the diagnosis of post-traumatic neurosis, even in the absence of all *clinical* signs of involvement of the brain. Encephalographic study in cases of this sort should be done and will give startling revelations at times.

6. It therefore follows that the careful handling of the patient at the time of the original head trauma is necessary if one wishes to prevent the occurrence of severe after-results.

7. The application clinically of the basic principles will do much to prevent invalidism after head trauma.

The Committee on Educational Policies of the Association of American Medical Colleges has recommended the following basic fundamental requirements for preparation for the practice of the specialties: Graduation from recognized medical college; one-year internship of general clinical work; residency or three years' experience under supervision or five years' general practice; not less than two years' graduate clinical work under supervision of a university.

Intra-Ocular Foreign Bodies

PAUL G. MOORE, M.D., Cleveland, Ohio

WE will discuss four important points of this subject:

The discovery of cases of intraocular bodies,

Their operative treatment,

Their after-care,

Their prognosis.

One of the most serious facts concerning intraocular foreign bodies is that they are frequently overlooked. Occasionally they are discovered only after serious damage has resulted to the injured eye or to both eyes.

A large number of intraocular foreign bodies are overlooked during their early history because the injured person regards the injury as trivial and seeks no medical attention, or ignores the injury entirely, because he has no pain. The small foreign bodies traveling at a high rate of speed are often felt only as a slight sting and cause no later discomfort so are disregarded entirely by the patient. His attention is next called to his eye when he notices the impairment of vision.

Some of these cases are overlooked at the time of examination by the physician due to the lack of care in the examination, or the lack of proper facilities for making the examination, or the lack of appreciation of what certain lesions of the cornea and iris mean. Intraocular foreign bodies must be discovered early and removed as soon as possible, if the cases in which they occur are to be treated successfully—in the first twenty-four hours if possible.

HOW ARE THESE CASES DISCOVERED OR DIAGNOSED?

Perhaps the oculist has an unfair advantage over the industrial physician in that every case sent to him is probably weeded out from among several other cases by the industrial physician as a serious case requiring special attention, consequently the oculist is on the alert for serious cases.

Every physician doing industrial surgery should be on his guard that one of these does not slip by him. It is to the credit of most of the industrial physicians that they are painstaking in their examination and a great many times diagnose these cases before they are referred to an oculist.

In taking the history of a traumatic case a clue may often be obtained as to the presence of an intraocular foreign body even before an examination is made. I am not referring here to the case with a very obvious injury; that is, with a gash across his cornea or with the contents of his eye ball presenting, but to the case which shows little or no trauma.

This patient may complain of a slight stinging pain in the eye which he calls to the attention of his fellow workman or his foreman. They assure him that there is nothing in his eye and he goes on working until the following day when he complains of a slight redness of the eye or a slight blurring of vision, or a slight stabbing pain in the eye when he closes the lids.

Occasionally two or three days pass by before the patient's attention is drawn to his eye and by this time the memory of any details of an accident have been forgotten. This failure on the part of the patient to recognize any injury for several days complicates the accident greatly, especially when it comes time to fix the responsibility for the same.

A number of intraocular foreign bodies are picked up in the patient's own home or private work shop or garage and he unintentionally in a great many cases puts the responsibility on some minor accident in his employer's shop.

The answer to the questtion, what were you doing when you were hurt, often gives us our first lead as to the presence of an intraocular foreign body.

Such answers as:

I was driving out a cotter pin,

I was setting a die,

I was chipping,

I was striking a hatchet with a hammer,

I was driving on a drift pin,

I was cutting a rivet,

indicate to me that the patient has been striking on hard steel with possibly a hard steel tool, and that I may expect to find a chip of steel somewhere in the eye.

THE CAUSATIVE FACTOR IN 41 CASES OF INTROCULAR FOREIGN BODIES

Explosion of Dynamite Cap	1
Breaking of Copper Wire While Reeling Same	1
Breaking of Lenses in Spectacles	2
Gun Shot Wound	1
Splinter from Head of Nail	1
Using Machine with Poorly Fitting Die	1
Striking Die with Hammer	2
Striking Chisel with Hammer	8
Striking Bearings with Hammer	2
Striking on Hardened Tools, as Reamer or Lathe Tools	4
Use of Trimming, Pressing, Shaper and Bolt Cutting Machines	4
Striking Steel Rod with Hammer	2
Striking Steel Keys	3
Striking Steel Spring	1
Striking Hard Steel Objects	8
Total 41 Cases	

Read before the Section on Public Health and Industrial Medicine, Ohio State Medical Association, at the 85th Annual Meeting, Toledo, May 12-13, 1931.

Foreign Bodies Other than Steel—	
Non-Magnetic	5
Steel—Magnetic	36

The following answers to the question what were you doing at the time of injury, are rather misleading.

I was knocking some paint from a spring,
I was driving tacks in upholstery,
I was reeling copper wire,
I was fixing a frozen water pipe.

Following the history a careful examination must be made. The examining physician owes to every case entering the plant dispensary, as an eye case, a careful examination of both eyes; not only for the protection of the patient, but the company employing him as well.

If the examiner has the proper facilities the examination need not take a great deal of time. The cases with a piece of carbon or emery on the cornea are very evident and require only a careful examination of the cornea and conjunctiva.

The ones we should be careful in examining, to prevent a serious case escaping us, are the ones showing very little injury and very few if any symptoms.

Taking up the subject of proper facilities for examining the eye: No other facilities are required for the discovery of intraocular foreign bodies than are necessary for the proper examination of any injured eye. It seems superfluous that we should mention this subject, but I have been in offices and also well known dispensaries where there were no adequate facilities for examining the surface of the cornea.

There is no excuse for not having the proper means for an eye examination, as they are not expensive or hard to obtain. The first article required for this examination is a comfortable chair for the patient. If nothing better can be had, use a large wooden arm chair. It is better to have a small head rest attached. Do not use a revolving stool or one of the ordinary metal chairs with a spring rod back and a revolving seat. I have seen these used with the doctor holding the patients head in his arm, his magnifying glass in his left hand and an eye spud in his right trying to remove a foreign body from the patient's eye.

After seating the patient comfortably, a strong light should be focused on the cornea of the eye to be examined. Day light is not sufficient nor is a 25 Watt lamp. It is not necessary to equip the office or dispensary with an expensive lamp. A 75 Watt bulb mounted on a movable bracket or standard is ample. The beam of light is much better if concentrated on the eye by means of a condenser in front of and attached to the lamp. A second condenser can be held in the hand close to the eye. (The first condenser can be purchased for $3.50 and the second for $1.50.)

The third essential in the examination is a magnifying glass, large enough to cover the field of the cornea, but not so large as to impede the movements in removing the foreign body. For my own use I prefer a 10 power Coddington loupe or magnifying glass.

When the wound of entrance is in the cornea the same can be discovered as a thin line or break in the corneal surface. Some physicians drop flourescine in the eye in order to disclose the break in the surface, but as a general rule a good light and a magnifying glass will disclose the wound.

A hole in the iris, blood in the anterior chamber, evacuation of or loss of the anterior chamber, one or all of these signs indicate a penetrating foreign body.

If the lens has been injured by the passage through it of a foreign body in a few hours there will be seen an opalescent sheen in the pupillary area due to the formation of a traumatic cataract.

Occasionally the foreign body slips around the lens and no damage is done to the latter. Therefore the absence of a traumatic cataract does not preclude the absence of an intraocular foreign body.

Again the foreign body may penetrate the anterior capsule of the lens and remain there. The wound in the capsule may close so that very little of the aqueous enters the lens tissue and only a very small cataract develops. These cases are easily overlooked.

Foreign bodies in the lens can be hidden behind the iris and easily overlooked. Especially is this true if ones attention is focused on a wound in the cornea in which there is a small foreign body present.

A hole in the iris strongly indicates the presence of an intraocular foreign body. Wounds at the limbus and through the conjunctiva and sclera are difficult to discover and a sub-conjunctival hemorrhage may cover a wound in the latter.

In all such cases an *X*-ray examination must be made to preclude the possibility of an intraocular foreign body being present as well as to localize it if it is present. *X*-ray localizations can be very accurately made, but the location may be one or two mms. off so that foreign bodies localized behind the retina may be really within the eye and may be seen lying on the retina. Examination of the eye with the ophthalmoscope often reveals the tract of the foreign body through the lens or the presence of the foreign body in the vitreous or retina.

When first seen the examination of the interior of the eye may be impossible due to blood in the anterior chamber, occlusion of the pupil or an opaque lens. As it is important to discover the presence of an intraocular foreign body as early as possible (in order to remove it before infection or organization of exudate sets in) an early *X*-ray examination is imperative.

The localization of the foreign body by *X*-ray also determines the size of the former and may be

of assistance in determining the manner of removal of the same.

The history of the accident, its mode of occurence, and the appearance of the external structures of the eye indicate whether an *X*-ray examination should be made. It is wiser to make too many *X*-ray examinations than too few.

THE DIAGNOSIS IN 41 CASES OF INTRAOCULAR FOREIGN BODIES WAS MADE BY

Presence of Wounds in the Cornea	in	10 Cases
" " " " " Cornea and Iris	in	13 Cases
" " " " " Cornea, Iris and Lens	in	5 Cases
" " " " " Cornea and Lens	in	2 Cases
" " " " " Cornea, Sclera, Iris and Lens	in	1 Case
" " " " " Sclera	in	6 Cases
" " " " " Sclera and Iris	in	1 Case
Presence of Glass in the Anterior Chamber	in	1 Case
Presence of Vitreous Opacities and Detachment of the Retina	in	1 Case
Presence of Siderosis of Iris and Lens	in	1 Case
	Total	41 Cases

In 15 of these cases the foreign body was seen within the eye on examination.

In 26 of these cases the presence of an intraocular foreign body was confirmed by X-ray examination and localization.

In 15 cases no X-ray examination was made, but in 9 of these latter cases the foreign body was seen on examination.

After the diagnosis has been made and the position of the foreign body determined the removal of the foreign body is indicated.

If some hours must elapse before a localization can be had some intermediate treatment must be instituted. The patient should first be relieved of pain, if he is suffering, by the use of a 4 per cent solution of cocain or a 1 per cent solution of butyn instilled into the conjunctival sac. As soon as the pain is relieved the patient relaxes and allows a more careful examination of the eye. In the majority of cases, the use of cocain is not indicated until operative procedures are started because often the patient suffers no pain.

The lids are to be cleansed and the conjunctival sac irrigated. If the corneal wound is extensive, efforts at cleaning should be avoided, the lids closed carefully and further manipulations put off until the patient is in bed or on the operating table.

If it is positive that the foreign body is not in the anterior or posterior chamber of the eye a 1 per cent solution of atropin can be used to advantage at this time. The atropin dilates the pupil and quiets the ciliary muscle so that later examination and operation are less painful and more easily performed. If the foreign body is embedded in the iris atropin should not be used until after the removal of the foreign body.

Our technic at this time is most important. A break in the technic now is as serious as in any operative procedure. One must not allow himself, by the pressure of the idea that something must be done at once, to be forced into making an unwise move without perfect technic.

I formerly removed the major number of intraocular foreign bodies in my office, but of later years have hospitalized all these cases. The latter manner of treatment has been most satisfactory. A large number of these cases have severe injuries to the internal structures of the eye. In removing the steel the iris may prolapse and the technic is more easily broken. One is to be criticized if he does not send these cases to the hospital when these facilities are available.

In removal of magnetic foreign bodies from the eye with the magnet two methods are used. The anterior and posterior route.

In the first method the Giant magnet is used and an attempt is made to bring the foreign body forward around the lens into the posterior chamber, then through the pupil into the anterior chamber and out through the original opening in the cornea.

In the second method an opening is made in the sclera and the tip of a small magnet is inserted and the foreign body is withdrawn through the new wound in the sclera.

One cannot abide by a fixed rule in these cases in deciding whether to use the anterior or posterior route, but must consider all the factors in each case and decide accordingly.

Where the injury to the cornea, iris and lens has been extensive, no more harm can be done by removing the foreign body through the wound of entrance. In fact, where the above tissues have been so extensively injured in all probability the removal of the eye may be necessary, if not at once, then in a few days.

In cases of intraocular foreign bodies resulting from the repair of automobiles or the scrapping of the same the foreign bodies are generally infected at the time of injury and a panophthalmitis, or infection of all of the eye tissues may be expected, with a subsequent removal of the eye ball.

Small foreign bodies, steel or iron in the anterior or posterior chamber are generally easy to remove if they do not become entangled in the iris or carry the iris into the corneal wound with them.

When entangled in the iris they cause the patient much pain especially in attempts to remove them and a general anesthetic may have to be resorted to before they can be removed. Much manipulation in the anterior chamber may injure the lens.

In several of my cases I have used the posterior route introducing the tip of the magnet into the interior of the eye, that is, making an incision in the sclera, but it must be kept in mind that in such cases a hemorrhage into the vitreous may result or later a detachment of the retina.

It has been suggested that the incision should be made through the sclera near the margin of the ora serrata where the retina is more firmly adherent to the scleral wall and thus avoid detachment to the retina if possible. (Two of the

cases reported in this series have resulted in detachment of the retina.)

In cases where the foreign body is small, one to two mms. in length, and of hard steel buried in the retina and choroid the use of the posterior route is almost imperative. They can hardly be attracted even by the Giant magnet, especially if enough time has elapsed following the accident for the foreign body to become fixed in a mass of blood clot or organized fibrin. On this account it is well to remove the foreign body in the first twenty-four hours if possible.

The harder and higher grade alloy steels which are the ones from which most of these foreign bodies come are not as magnetic as the softer iron, consequently are not so easily attracted by the magnet.

The withdrawal of a piece of steel from the retina or vitreous, around the lens through the Zonule of Zinn and into the anterior segment of the eye is an interesting and intriguing operation. It can be done, but injury to the lens must be guarded against, also entanglement of the foreign particle in the ciliary muscle.

As the distance between the metal and tip of the magnet lessens the speed of the foreign body increases, also the force with which it travels, so that some unexpected injury may occur to the iris or the lens. Occasionally a steel chip is jerked into the iris instead of passing smoothly from the posterior chamber through the pupil as is expected.

AFTER-TREATMENT

When the foreign body has been in the anterior chamber and its removal has been accomplished without complications the treatment is simple. If there has been no injury to the iris atropin may not be needed. An antiseptic solution is used in the conjunctival sac such as mercurochrome 1 per cent solution or zinc sulphate 1/5 per cent.

If there has been an injury to the iris, if it has been pulled upon in removing the foreign body, if there has been any blood in the anterior chamber or if the manipulation of the eye ball in removal of the foreign body was at all severe, atropin must be used, also if there has been injury to the lens or the foreign body lies posterior to the lens, atropin is indicated.

When the capsule of the lens has been injured the lens tissue becomes opaque and if the opening in the capsule is large the change takes place quite rapidly even in twenty-four hours. This opaque material may later be entirely absorbed leaving a clear pupil or one partially closed by portions of the remaining lens capsule. The nuclear portion of the lens may be quite hard and require removal by operation later. The absorption of the lens material keeps the eye irritable and red for several weeks and delays the recovery.

During the first three or four days after the accident ice compresses are sometimes used. I have always used hot compresses instead, and believe this treatment gives more relief. The use of the heat lamp using a burner giving off red heat rays gives a great deal of comfort to the patient, and stimulates recovery from the injury.

These cases as a general rule are not painful unless severe injury has occurred to the iris or ciliary body, or the lens has been injured and is swelling rapidly with increase of intraocular tension.

Cases in which an iritis or a cyclitis, or uveitis develop are given mercury and potassium iodide, occasionally neoarsphenamin is used to advantage.

In cases where these inflammatory processes are severe typhoid vaccine is given intravenously starting in with a dose of 15 million and pushing it up to 500 million.

PROGNOSIS

In making a prognosis in these cases one should be extremely cautious. (See following chart for results in this series.)

THE END RESULTS IN 41 CASES OF INTRAOCULAR FOREIGN BODIES

The Injured Eye was Removed in			12 Cases
Due to Severe Wound in Ciliary Region in			5 Cases
Due to Infection in			4 Cases
Due to Glaucoma After 5 Years in			1 Case
Due to Sympathetic Iridocyclitis in			1 Case
Due to Lead in Eye Ball in			1 Case
The Vision was Destroyed by Vitreous Opacities in			3 Cases
The Vision was Destroyed by Detachment of Retina in			3 Cases
Cataract Resulted in			6 Cases
Vision of	20/100 or 48.9%	Was Obtained in	1 Case
	20/70 or 64%	Was Obtained in	2 Cases
	20/40 or 83.6%	Was Obtained in	1 Case
	20/32 or 90%	Was Obtained in	2 Cases
	20/24 or 95%	Was Obtained in	3 Cases
	20/20 or 100%	Was Obtained in	8 Cases
		Total	41 Cases

In twelve cases the eye was lost. Five of these required enucleation on account of severe injury to the ciliary body. Several weeks intervened between the time of the accident and the enucleation. Every effort was made to save the eye for I believe that an eye ball though blind is an advantage to a workman over a glass eye.

When sufficient time has elapsed in which the injured eye may quiet down and it still remains irritable to light, painful, with loss of all useful vision, and causing loss of time from work at irregular intervals then the eye should be removed.

Four of this series of cases were infected at the time of injury and rapidly developed an inflammation of the entire ball, requiring enucleation. Two of these cases occurred in men making repairs to automobiles.

One case developed a glaucoma five years after the accident and the eye being blind it was removed to relieve the intense pain.

One case developed a sympathizing iridocyclitis on the 88th day after injury, which quieted down after the removal of the injured eye.

Detachment of the retina occurred in three cases.

Cataract resulted in six cases.

LENGTH OF TIME LISABLED

Greatest Number of Days in Hospital	58
Least Number of Days in Hospital	3
Average Number of Days in Hospital	19.9
Greatest Number of Days Disabled	136
Least Number of Days Disabled	8
Average Number of Days Disabled	44.13
Average Number of Days in Hospital Following Enucleation	9.22
Number of Cases Hospitalized	27
Number of Cases Ambulatory	11
Number of Cases not Disabled	3

SUMMARY

1. All cases of eye injuries must be examined carefully, as intraocular foreign bodies are often overlooked.

2. Proper facilities for examination should be provided. They are not expensive or hard to obtain.

3. The removal of intraocular foreign bodies is difficult.

4. Their treatment is long and tedious.

5. The prognosis is very uncertain, a great many times the eye is lost, and many times surprisingly good results are obtained.

1701 MEDICAL ARTS BLDG.

DISCUSSION

WEBB P. CHAMBERLIN, M.D., Cleveland: To all physicians engaged in the practice of industrial surgery the subject of eye injuries is an important one. This is especially true of those cases in which a foreign body has penetrated the eyeball. Upon the early recognition and prompt treatment of such cases depends in large degree the subsequent usefulness of the eye.

To industrial surgeons the question of greatest importance concerning intraocular foreign bodies is that of diagnosis, for few would care to assume the responsibility of the treatment of such a case. But the industrial surgeon can not evade the responsibility of diagnosis—for it is to him these cases first go for help.

Diagnosis may be very simple, so simple that any layman could make it, as when a large foreign body has penetrated the eyeball with immense damage. Or it may be extremely difficult as when the foreign body is small and has done little damage to important structures. It is this latter group in which we are most interested. In the former group vision has already been destroyed, but in the latter your correct diagnosis will save many eyes which would otherwise be lost.

Evidence of intraocular foreign bodies is both subjective and objective.

Of the subjective symptoms pain is often misleading. Pain is usually less severe than in the ordinary foreign body imbedded in the cornea. In fact it is often so slight that the patient himself does not realize the seriousness of his injury. A subjective symptom of much greater importance is impairment of vision. This, in a case of apparently trivial injury, should always arouse our suspicion. This disturbance of vision may be a general dimness indicating blood in the aqueous or a cloudiness of the lens, or it may be large black spots floating before the eye, indicative of blood clots in the vitreous.

Objective evidence of penetration of the globe may be obtained in three ways. First, with a corneal loupe of some kind. By its use all corneal abnormalities are enlarged so they can be readily seen. Many abrasions otherwise undetected will be seen in this way, especially if fluorescin is used. I always regard abrasions and minor lacerations of the cornea with extreme suspicion if they occur in a patient who has been engaged in chipping or the other occupations mentioned by Dr. Moore. With the loupe the aqueous may be examined for blood—another evidence of a penetrating wound. Also the iris for lacerations or tears. In some cases the foreign body itself may be plainly seen imbedded in the iris. Traumatic opacities of the lens can also be seen with the loupe. The hand slit lamp is equally satisfactory for this external examination.

The second method for eliciting evidence of an intraocular foreign body is with the ophthalmoscope. This will show cloudiness of the media, floating opacities of the vitreous, opacities of the lens and in some cases the foreign body itself. Every industrial surgeon should be sufficiently familiar with the use of the ophthalmoscope to make this examination.

The third and most reliable of all methods of obtaining evidence of an intraocular foreign body is the *X*-ray. It should be used in every suspicious case. Every abrasion or laceration of the cornea in a patient from the above mentioned occupations is ample justification for its use. It should be used far more frequently than it is. Many surprises will result from its more general use. Nevertheless the *X*-ray, our most valuable aid in diagnosis, is not infallible, even in the hands of experienced men. A negative *X*-ray does not always mean the absence of a foreign body. It may be glass or some similar substance which does not show on the film. Sometimes even a small piece of steel does not show. I recently had a case in which a piece of steel could be plainly seen in the iris, and which responded to the magnet and yet it did not show on the film, even on repeated examinations.

A word regarding localization. A skilled *X*-ray man can localize a foreign body within one or two millimeters. This is sufficiently accurate for most purposes. There are cases, however, when a difference of one or two millimeters would be the difference between an intraocular foreign body and one outside the eyeball posteriorly. It is my practice to consider a foreign body as intraocular unless more than one millimeter posterior to the globe on repeated localizations. This is many times of importance. All intraocular foreign bodies should be removed, while those which have passed through the eye into the orbit may safely remain.

There is another method of examination which in my opinion should never be used. I refer to the use of the magnet for the purpose of diagnosis, the so-called magnet test. I believe the magnet should be used only for the removal of a foreign body after careful localization, and never for the purpose of diagnosis. I mention its use in any other way only to condemn it, in an eye in which there is any hope of vision.

So while no one subjective symptom is conclusive, and many of the objective symptoms are only suggestive, I believe that if the history is carefully taken, if the subjective symptoms are given proper consideration and if all three methods of obtaining objective evidence are used, cor-

neal loupe, ophthalmoscope and *X*-ray, very few intraocular foreign bodies will be overlooked in the group of cases where diagnosis is often difficult but of extreme importance.

M. W. JACOBY, M.D., Cleveland: I believe that Dr. Moore's paper is particularly valuable because it represents his personal observations and no one can be more fair or critical in evaluating the results of his own work. He has had a large experience in this field and further, has had a wonderful opportunity to study the end results obtained by other operators in his capacity as examiner for the Ohio Industrial Commission.

Dr. Chamberlain has discussed the question of diagnosis and I have nothing more to add other than to further emphasize the importance of *X*-ray examination of all suspected intra-ocular foreign bodies.

Such examination reveals the number of foreign bodies, their size and location, and should be made immediately after the preliminary examination of the injured eye, before any attempt at removal is made. The location of one foreign body without *X*-ray should not rule out the presence of others.

Careful *X*-ray technique is very important and a negative report with disputing clinical findings should call for a recheck.

I have seen two cases which had been under treatment for iritis on the strength of negative *X*-ray findings. A second *X*-ray examination not only localized but measured the foreign bodies. In both cases enucleation was imperative.

The question of treatment has been well covered by the essayist. Removal by the anterior or posterior route is entirely dependent upon the size, location and site of entrance of the foreign body. Both methods have their disappointments.

With proper care I do not believe injury to the lens will occur through the anterior route as the foreign body will tend to follow the channel of entrance as a course of least resistance. On the other hand the detachment of the retina which does occur only too often, probably does not occur as often as many times represented.

Final results will show many wide variations but there are very many bad results as measured by the number of enucleations and eyes with useless vision.

Haab of Zurich reports in 165 cases 23 per cent enucleations and 43 per cent cataract operations. Successful removal of steel lodged back of the iris and lens occurred in 83 per cent of 134 difficult cases.

Sydney Walker of Chicago in 350 intra-ocular steel cases reports 60 per cent enucleations; retained blind eyes 16 per cent, useful vision 8 per cent, good vision 12 per cent, excellent vision 4 per cent and sympathetic ophthalmia in 1 per cent.

All of the figures given show how serious these intra-ocular steel injuries are and speedy diagnosis is one method which will help to lower these bad results.

Delay in removal of a useless and inflamed globe should not be tolerated.

Just a few words about non-magnetic foreign bodies. It is entirely probable that not much is to be accomplished for those foreign bodies not readily grasped with instruments. When located in the vitreous or lodged in the posterior coat of the bulb it is a difficult matter to grasp it without producing serious immediate or subsequent injury to intraocular structures.

It is always worth while to attempt their removal after careful localization. The use of a double plane fluoroscope would often be of great help in these cases but such equipment and its expert operation is not readily obtainable.

In closing I would like to add that lime glass will throw an opaque shadow sufficient for diagnostic purposes in contradiction to the belief that it will not. In fact, practically all glass injuries are of the lime glass type today as there is very little lead glass in commercial use.

NEW BOOKS RECEIVED

The Genius of Louis Pasteur, by Piers Compton; the life and discoveries of the brilliant French scientist; The Macmillan Company, 60 Fifth Avenue, New York, publishers; $4.50.

Human Sterilization, by J. H. Landman, Ph.D., J.D., J.S.D., The College of the City of New York; a treatise on the scientific, legal and social phases of human sterilization; The Macmillan Company, 60 Fifth Avenue, New York, publishers; $4.00.

Foods in Health and Disease, by Lulu G. Graves, consultant in nutrition and diet therapy and honorary president of the American Dietetic Association; a practical text on food materials, their production and transportation, their care in the home and in the market; their dietetic value; classification, etc.; The Macmillan Company, 60 Fifth Avenue, New York; $3.50.

Nutrition Service in the Field and Child Health Centers: A Survey; publication of the White House Conference on Child Health and Protection, combining a report of the sub-committee on nutrition and a report of the sub-committee on health centers; The Century Company, 353 Fourth Avenue, New York; $2.00.

Obstetric Education, a publication of the White House Conference on Child Health and Protection; report of the sub-committee on obstetric teaching and education; The Century Company, 353 Fourth Avenue, New York; $3.00.

Growth and Development of the Child, Part 3: Nutrition; publication of the White House Conference on Child Health and Protection; report of the committee on growth and development; The Century Company, 353 Fourth Avenue, New York; $4.00.

Commencing September 1, 1932, candidates for admission to the freshman class of the College of Medicine, University of Cincinnati, must present official evidence of three years' college preparation of not less than 90 semester hours in a college of satisfactory standing, including the following subjects: Chemistry 16 semester hours, one-half of which to be laboratory work; zoology or general biology, eight hours, four hours of which must be laboratory work; general physics, eight hours, of which two hours must be laboratory work; English, six hours; foreign language, six hours; embryology, four hours.

Facts About the Injection Method of Treating Hemorrhoids

WELLS TEACHNOR, SR., M.D., F.A.C.S., Columbus, Ohio

THOSE who have had wide experience, either as general practitioners or surgeons, no doubt will readily agree with those who have made a specialty of treating diseases of the rectum that there is no condition of more common occurrence and which becomes more acutely painful when inflamed than the varicose conditions of the hemorrhoidal veins, causing painful swellings at the anus, commonly known as hemorrhoids.

INJECTION TREATMENT

The injection treatment of internal hemorrhoids constitutes by far the largest field of what is termed the ambulant method.

Unfortunately, the injection method has been used more extensively by irregulars, quacks, and incompetents than by those members of the regular medical profession fully competent to apply it in the treatment of internal hemorrhoids and with fair assurances of success.

The purpose of this paper, therefore, is to urge well qualified members of the profession to seriously consider the advantages of this type of treatment in selected cases, and to analyze the technic which may be employed.

H. Graeme Anderson, in a discourse in the *British Medical Journal*, on the injection treatment of hemorrhoids, reports that as far as is known, it was first used by a Mr. Morgan in Dublin in 1869, a solution of iron persulphate being injected. According to Anderson, carbolic acid was first used as the injecting agent by Mitchell of Clinton, Illinois, in 1871.

As pointed out by Anderson, almost from the beginning, the injection method was employed by quacks and irregulars, the ignorant and irresponsible, in such an indiscriminate manner that serious complications and even disasters occurred, causing the method to fall into disrepute despite the fact that even in the hands of the most ignorant, successes were obtained.

Many members of the medical profession came to regard the injection method with distrust because it was practiced by the quack and irregular. It was termed dangerous as well as worthless. Surgical text-books devoted little, if any, space to its consideration, and if they mentioned it at all, it usually was decried as dangerous and useless. For many years, the profession was extremely skeptical about using it, and much ill-feeling arose between its proponents and opponents.

Today, the injection method is practiced quite extensively by proctologists in this country and abroad in a large number of selected cases. It has been established as a reliable method of treating many cases of internal hemorrhoids. In fact, there are few cases that will not yield to it if utilized by men of skill and experience. Many surgeons still are limiting the injection method to the exceptional case in which operation under general anestheia would be contra-indicated, or to those in which an operation is rejected because of the loss of time. It seems to me, the first is a sufficient reason why it should be used more extensively, for if it will cure cases complicated by other diseases or disabilities, it certainly is indicated in the uncomplicated case.

REVIEW OF THE LITERATURE

Recently I reviewed the literature on this subject for the past twenty years. The great majority of authorities are quite enthusiastic about the injection method of treatment in selected cases, and are of the opinion that it may be used with success in a large percentage of cases which are uncomplicated.

Boas, considered by many to be the foremost authority in Germany upon diseases of the rectum, concludes, after observing cases from 1915 to 1919 inclusive, that the injection method is indicated in preference to operation in cases of uncomplicated internal hemorrhoids in persons suffering from diabetes, nephritis, senility, and either primary or secondary anemia. Other authors of the same country who comment favorably upon the injection method of treating hemorrhoids are Barth, Bonheim, Von Noorden and Krukenberg.

English proctologists in general are enthusiastic over the careful use of the injection treatment of hemorrhoids. In fact, it has been the method of choice in England for many years. Sir Gordon Watson and Mr. Mummery freely state their faith in its value in certain types of hemorrhoids. Mr. Anderson, previously quoted, holds the method in high favor, while Ball, Alexander, and Murphy have reported remarkable successes. It is noted in the various articles written by these and other British authorities, such as Morely and Swineford Edwards, that in England the solution which is almost always used is a carbolic-glycerine mixture in a strength of 20 per cent. The use of quinine and urea-hydrochloride has never been regarded favorably there, chiefly because English proctologists are well pleased with the results obtained from the use of the carbolic-glycerine solution.

Mr. Morely writes that he has treated hundreds of cases over a period of thirty years by this method, and claims that 80 per cent of all cases can be successfully cured. His monograph dealing entirely with the etiology and injection treatment of hemorrhoids merits careful study.

Mr. Swineford Edwards, dean of English proctologists, in an article in the *Practitioner*, in 1915,

Proctologist to Mt. Carmel Hospital.

Read before the Columbus Academy of Medicine.

gives a resumé of the conclusions he has reached after twenty-five years' experience with this method. He believes that many cases of internal hemorrhoids require no operation, since they can be dealt with successfully by the injection method. He further states that the cases suitable for injection are those of reducible internal hemorrhoids which are uncomplicated by external tags, fissure or fistula.

In our own country, Terrell advocates the use of 5 and 10 per cent solutions of quinine and urea. He reports a large number of cases of internal hemorrhoids, with protrusion and bleeding as their chief symptoms, successfully treated with this solution. He does not consider the injection method suitable for inflamed, strangulated, or external cutaneous tags.

Collier F. Martin has used the carbolic-glycerine mixture for many years, and reports that he has met with praiseworthy success. Hirschman has used the method with equally gratifying results in selected cases. Early says he has found the injection method a valuable adjunct, while Jackson and Fansler both consider the method a valuable addition to the therapeutic armamentarium of the proctologist.

Gant says simple internal hemorrhoids will disappear almost like magic under the injection method. He puts 50 per cent of all hemorrhoids in that class. J. R. Pennington declares 50 per cent of all hemorrhoids can be cured in this manner, while T. Chittenden Hill claims 65 per cent.

Gay believes the method in the hands of reliable persons and in selected cases is meritorious, pointing out that it has been brought into some disrepute by being applied to unsuitable cases; by using a preparation of too great strength and in too large quantities. Terry concludes that there can be no question but that all cases of internal hemorrhoids can be benefited, and many cases can be completely and practically painlessly cured by the injection method.

Returning to the observations of some of the other foreign authorities, Eadie of England, after 2,000 injections, declares that this method is to his mind the treatment of choice for primary hemorrhoids, and the one to which he would prefer to submit himself. Sir James F. Goodhart observes that it is a valuable means of treating hemorrhoids, and is not resorted to as often as it should be.

Jose M. Jorde, writing in the Semana Medica, Edmendo Escomel of Peru, Bensaude in France, Hooten in India, Berguland in Norway, all have found this non-operative method to be of no value.

These reports, and many others which I have available, as well as my own personal experience of twenty-five years, are, in my opinion, sufficient evidence and authority to justify a description of the injection method, and to establish it as not only ethical, but just as radical in properly selected cases as any other known operation.

For a number of years I have been treating hemorrhoids in this manner with very gratifying results to both myself and the patient. Of course, there are still some facts concerning its action that are indefinite and cannot as yet be satisfactorily explained.

There are a few cases that will not yield to the treatment. The ability to distinguish these cases is acquired by years of experience and practice. A study of the patient's temperament, habits and general physical condition enters into each case, and may have a decided influence on the degree of success obtained. Those who use this method routinely and have no hospital connections, will undoubtedly have some failures.

POSITION OF PATIENT

The most convenient position for the patient, and the one I always use for both male and female, is the left lateral or Sims' position. I never have been especially troubled in making a complete and accurate exposure of the parts to be treated.

ENEMA UNNECESSARY

An enema should never be given before proceeding to inject hemorrhoids. It is always a troublesome precaution and of no special value. We may ask the patient to take a physic two days before the date for the treatment. The rectum normally is an empty organ, and the field will not be obscured if left in its natural state.

THE SOLUTION

The solution for injection which I recommend and which I have used for a great many years, is pure carbolic acid, 10 per cent, in oil of sweet almond, 90 per cent. My experience with this solution has been so satisfactory that I have never thought it advisable to change. In some cases of very large pile tumors I have used the same formula in a 20 per cent solution. With this strength I have probably obtained a more rapid result, but at the same time a much more severe reaction. The 20 per cent solution will in some cases produce a sloughing of the mucous membrane. However, I never have found this to be a severe complication, and would recommend the occasional use of the stronger solution in cases which experience has taught cannot be cured by the weaker solution.

The 10 per cent solution will not cause an ulceration if properly injected. The number of injections may be materially increased in stubborn cases, and I believe it to be a safer and just as effective method as that of using the stronger solution in a single injection. In a small number of cases, I have had to repeat with one or two injections, three or four years after the original operation; but this never has been considered a great inconvenience by the patient.

Many solutions of varied strength have been

used. Some of them have contained as high as 95 per cent carbolic acid, and very frequently 50 per cent. Naturally, solutions of such strength always will produce considerable after-pain and a great amount of sloughing which might result in failure, or even a fatality.

All solutions which are effective contain a percentage of carbolic acid as the chief ingredient in either a menstrum of glycerine or oil. In my experience, the oil solution has caused less pain than any other. Some years ago I abandoned the glycerine solution, believing that it caused more pain than from the oil mixture. All of these solutions are strongly antiseptic, and do not need to be boiled before use. The carbolic acid dissolves completely in the oil of sweet almond. It never precipitates, and settles to the bottom of the bottle. However, this is a point that must be carefully looked after. If such should occur in any solution, the strength will be altered, and the last in the bottle might consist of pure carbolic acid. This, of course, might produce serious and annoying complications. The operator should always shake the bottle before withdrawing any of the solution.

A 5 to 10 per cent solution of quinine and urea hydrochloride has been recommended. I have used it in some cases, but with rather indefinite results. It surely has no permanent curative effect when injected into the piles, and it is neither an astringent nor an escharotic. In subcutaneous use, it has been almost entirely discarded because of sloughing of the tissues into which it is injected. For the same reason, I would hesitate to inject it directly into a mass which is entirely covered by mucous membrane. However, those advocating its use claim that it will not cause sloughing when injected into the sub-mucous tissue in the anal canal. Judging from my own experience, sloughing is a possibility when this solution is injected into any tissue of the body. Therefore, I think that it should never be used, first, because it does not possess the properties and ingredients that are curative, and, second, because there is always the possibility of infection from the resultant sloughing.

TECHNIQUE

The technique that I now describe in detail is one that I have successfully used for more than twenty years.

In loading the syringe with the solution, the operator or his assistant should make sure that no air bubbles remain in the syringe. Thick viscid solutions take some time to flow through the needle, and where a needle of large caliber is used, air may find its way into the syringe.

To expose the piles, I use the ordinary anoscope introduced in the usual way. After the patient has been asked to strain down gently, the piles will be seen to fall into the anoscope, and come readily into view as the instrument is slightly withdrawn to the point where you desire to make your injection. The parts should then be swabbed with a 1 per cent solution of mercurochrome. All traces of fecal matter are in this way removed, and any surplus fluid is then mopped out with a dry swab. A good artificial light is essential. I use a large electric headlight that throws its rays into the instrument and upon the field.

It is wise never to inject more than two hemorrhoids at one time. The largest pile should always be injected first. In a majority of cases it is in the right anterior anal quadrant, and the one in which the prolapse comes most readily. This gets the larger one, often the cause of all the trouble, out of the way first, eliminating at the beginning the source of a large part of the trouble, and removing the tumor which may be obscuring smaller piles in the other quadrants. Often it is not possible to treat more than one pile at a time because immediately after injection, the hemorrhoid swells rapidly, obscuring others that may be present. Furthermore, most proctologists advise against injecting more than one or two piles at a time, declaring that if all present are treated at one time, there may be much discomfort which defeats the purpose the operator wishes to accomplish, namely, to keep the patient on his feet and going.

I cannot emphasize too strongly the fact that the operator must be quite certain that he has not overlooked the smaller piles that may have been obscured by the larger ones. The smaller piles which have been overlooked may develop to such size as to cause the patient to believe that the treatment has not been satisfactory. Also, the ones which are overlooked are the ones that develop and appear later as a recurrence. Patients should be told of this possibility, and made to understand that they should return for treatments, until discharged. If a permanent cure is affected, all tumors and dilated veins in the pile bearing area should be obliterated.

Hemorrhoids should never be injected while prolapsed. I would especially warn against this. Always reduce them before the injection is made. I will admit it is a temptation to inject them when they are prominent, but when they are prolapsed it is impossible to make out the anatomical relations accurately, and the swelling which occurs so quickly after injection is almost certain to complicate reduction.

Should you have enough bleeding on exposure to obscure vision, the instrument should be tilted slightly downward, and the blood will readily escape when pressure with a dry cotton swab is applied. The bleeding stops instantly when the hemorrhoid recedes.

An ordinary hypodermic syringe made entirely of metal, which can be sterilized by boiling, has been found practical. The metal is unaffected by the solution I employ. The syringe is made to hold 30 mm. which is sufficiently large to inject

four or five medium sized hemorrhoids without refilling. The piston is graduated, and is provided with the usual mill screw so that the required number of drops can be accurately measured for each tumor. It is provided with finger grips which give a sufficient amount of control. The needle should screw on the syringe and should be of fairly large bore. I use a twenty-two gauge, one inch in length. Some operators use a syringe with a shank so that there may be an unobstructed view of the point of the needle throughout the operation. This is unnecessary if the piles are properly exposed. A basin of weak lysol solution with plenty of cotton swabs should be at hand, as well as plenty of vaseline and a bowl for soiled swabs. All instruments should be carefully sterilized. I have never had any infections, and believe that this complication can most always be avoided if the proper degree of care is used.

The needle should be introduced into the most prominent point of the tumor after it is exposed, and pushed into the center of the pile in the long axis of the anal canal to near its superior pole. If the pile is very large, the needle should be inserted at least one-half inch. I usually use a needle one inch long from the shoulder.

The solution is injected slowly. The needle should not be withdrawn at once, but should be allowed to remain in position for two or three minutes. In very large tumors, the needle may be turned either to the right or the left from the center, and two or three drops of the solution deposited. In this way the entire mass is infiltrated with the solution without withdrawing the needle.

About the time the needle should be withdrawn, the tumor becomes considerably swollen, and the surface becomes whitened; also, a few superficial capillaries may be seen running in various directions over the surface. This always is a favorable sign, and assures the operator that the injection has been made in the right manner. Blanching does not always occur, but that does not imply that the injection has failed. You should not be tempted to inject more of the solution simply because this typical reaction is not present. Care should be taken when the needle is withdrawn as there is a tendency toward loss of the solution through the hole caused by the needle. This may be remedied by placing a dry cotton swab against the tumor, and pressing it as high as possible into the anal canal before withdrawing the needle.

The quantity of 10 per cent solution injected into each pile is from 3 to 5 gtts., sometimes less, never more, depending on the size of the pile. A correct dosage is learned only by years of experience and by watching the immediate effects in many cases. Never make the injection at a low point. It must be in the pile-bearing area which is in the distal inch of the rectum. The area is insensible to pain, and can be cut, burned or pulled without local anesthesia. Each pile should be injected in the manner described above. The whole procedure takes from five to seven minutes. Larger piles may have to be injected a second time, and possibly a third time, as one never can tell just how many injections will be required to produce sufficient sclerosis of the tissue to affect a cure.

INTERVALS BETWEEN INJECTIONS

If the 10 per cent solution is used, I usually try to make two injections a week. Of course, this depends largely on the amount of reaction obtained from each injection. If a 20 per cent solution is used, the injections should be made a week apart. In a week's time following the injection of the stronger solution, the reaction from the preceding injection should have subsided, and the operator should be in a position to judge of the necessity for a second or third injection, and the quantity of solution which should be used. Four or five days after each pile has been injected, it can be felt as a hard ridge along the rectal wall in its long axis. Internal hemorrhoids cannot be palpated when above the sphincter muscle before they are injected.

Injections should be continued until no trace of the tumors can be seen. On an average, this will require from five to seven injections. It may require ten or twelve—no one can tell—and it all depends upon the amount of effect you get from any such injection. A pile that has assumed a firm hard mass, and stands out prominently on the wall of the anal canal, should not be injected, as a second injection into this hard area may cause sloughing.

Patients, I have found, do not object to repeated injections, and will travel long distances to keep their appointments rather than undergo an operation. There seems to be a great fear of the knife in the treatment of rectal diseases. This is largely due, I believe, to the fear of loss of function of the bowel, instilled into many persons by the quack and irregular without hospital connections, in an effort to prejudice his clientele against surgery in rectal disease.

It is unnecessary to keep the patient in bed following these injections. I always advise them to go about their business in the customary manner after a few hours' rest. I also always warn patients that the piles should be reduced if they prolapse after treatment. Applications of cold water and plenty of vaseline will aid greatly in accomplishing this. I have found it advisable to explain to the patient that temporarily the piles become larger, and that should they stay below the sphincter muscle for any length of time, they will become strangulated and cause a great deal of suffering. Patients, likewise, should be warned against taking a drastic cathartic on the day after the operation as an increased number of bowel movements and straining might cause prolapse.

Occasionally I have had a patient complain of some discomfort while the injection is being made.

However, I have found that the introduction of the anoscope where the sphincter muscle is spasmodic usually causes more real pain and discomfort than any other part of the treatment. A slight aching is not uncommon, and usually comes on two or three hours after the treatment.

COMPLICATIONS

I have never experienced any serious reactions or bad effects, either local or constitutional, after injections. Some patients suffer more discomfort, not actual pain, than others, as injection made in exactly the same manner may cause little or no discomfort in one person and considerable in another. I have never known this to be sufficient to incapacitate patients from their usual vocations.

If a pile prolapses after injection, it must be promptly reduced or it will become very sore. As this may happen, the patient should always be warned and instructed to replace it as soon as possible. Most patients are accustomed to this procedure, and do it with very little inconvenience. The usual cause is a thrombosis which is due to injecting the pile while it is strained too low in the anal canal.

Injection of too much fluid may cause sloughing, or injecting too low down near the anal margin and anal valves, will cause more pain. While these reactions are not serious, they are easily avoided if the proper technique is used.

Sepsis is unknown in my experience. However, this is one of the complications pointed to by the opponents of this method. I have never seen an abscess from this cause in all my practice. If the injection is made directly into the exposed pile, and not into the underlying tissues or skin tags, I am sure you need have no fear of abscess or sepsis.

I have seen irritation of the bladder occur a few times in elderly men with enlarged prostate. This is not serious, and may occur in a patient with inflamed hemorrhoids from any cause.

Hemorrhage might be a serious complication. It is always due to sloughing of the tissues and exposure of a blood vessel, caused either from the use of too much solution or an injection improperly made. I have recorded slight bleeding with the passing of clots seven to ten days after injection on several occasions, but never enough to cause alarm. Prolonged bleeding rarely occurs as the blood vessels soon become closed, especially after the pile has been pushed above the sphincter muscle which process causes the pile to collapse. Two cases in twenty-five years' experience have given sufficient cause for anxiety and alarm. Both were packed and the bleeding stopped immediately. One of these was subsequently transfused. In my own experience, secondary hemorrhage after excision operation is more frequent than from injection. I have seen many such accidents following excision that required almost a re-operation, with a great deal of anxiety for both the patient and the surgeon.

Recently Dr. Curtice Rosser of Dallas, Texas, writing in the *Journal of the American Medical Association* for May 23, 1931, commented on observing anal stricture which he attributed to the injection of escharotics for internal hemorrhoids, and reports several cases. I have never observed this complication in my years of experience.

CONTRA-INDICATIONS

The chief contra-indication to this method of treatment is the presence of several rectal conditions in connection with the piles. The injection method is not applicable to all cases of hemorrhoids. Its practice should be limited to a case that protrudes with each movement of the bowels and collapses when returned above the sphincter muscle. This is the predominating symptom in the majority of cases of internal hemorrhoids. Cases complicated with fissure, spasmodic sphincter, or acute inflammation and strangulation, should not be injected. Palliative measures should be employed until all the inflammation subsides.

It is claimed by some that the results of the injection method are not permanent. I believe this is untrue in cases where the injection has been properly executed. The failures in my experience have been due to not treating the piles long enough or in overlooking one that later develops and causes trouble.

Treatment by injection is always contra-indicated when strangulation is present. In such cases an operation should be performed without delay. The best operation, at least the one that has served me best in such cases, is incision and suture with ligation of bleeding points under local anesthesia.

HOW THE INJECTION CURES; RECURRENCES

Naturally, an interesting question is the manner in which carbolic acid brings about a cure of hemorrhoids.

The immediate effect following injection of the solution is a swelling of the piles, due to the overflow of blood serum in the submucous layer. The effect of this is to produce an aseptic inflammatory process which causes a sclerosis of the tissues and adheres them to the anal wall; it tends to contract and cause obliteration of the dilated veins of the piles, and at the same time produces a sufficient amount of adhesions between the mucous membrane, submucous and muscular coat of the anal canal to hold the mucous membrane and prevent it from protruding or sliding down at the time of stool. This may last for years or even a lifetime; in many cases it will. A small number of cases may require additional injections after long periods of time, especially if the patient is under thirty years of age.

Hemorrhoids are primarily dilated or varicose veins which coalesce and gradually develop from

rectal irritation and the obstruction of the return flow of blood in the veins, until they are large enough to protrude. Before thirty years of age, all veins will not have been variocosed. Therefore, while you may have cured all the piles that existed in a person thirty years of age or younger, others may develop in later years from the causes that produced the first piles. This may happen in connection with almost any operation.

CONCLUSIONS

The advantages of this method of treatment over confining operations are obvious. Neither work nor pleasure is interfered with; neither preparation nor anesthetic is required, and if carried out carefully and with reasonable dexterity, extremely favorable results will follow.

When used by the skilled proctologist who possesses a broad medical and surgical knowledge of the diseases of the rectum and allied complications, and who has the training and experience to judge as to the kinds of treatment proper for certain types of rectal ailments, the injection method of treating hemorrhoids has produced, and will continue to record, permanent and beneficial results of inestimable value to humanity.

Of course, this is a splendid field for the practice of deception in the hands of the unscrupulous. An external thrombotic hemorrhoid, a small anal papillae or other trivial conditions may be magnified to make the patient believe that it is a serious condition, demanding immediate treatment which can only be relieved by a "special system." To do this, soon brings any method into disrepute. The irregular gets the best results simply because in most of his cases nothing is the matter.

It is an entirely safe and commendable procedure in uncomplicated cases. It is not without danger, of course, and certainly requires as much skill and knowledge as surgical removal. As stated previously, the method is capable of bringing about a cure if administered by a recognized surgeon who has received training in its method of application. It is economic; causes no pain, no shock, and no danger of immediate hemorrhage as from surgical excision. The patient should know that the treatment often extends over a considerable period of time, and that he should be kept under observation for a long time to obtain lasting results.

If all these conditions are explained to the patient, and the operation is done without a guarantee, backed by a monetary deposit, that they are receiving a "special secret system" of treatment, not known by other physicians, for which an unreasonable charge is made, and when trivial ailments are not exaggerated into serious ones for the purpose of giving treatments or charging a fee out of proportion to the seriousness of the condition and the amount of work done, then you are justified in giving this method of treatment in uncomplicated cases, and to those persons for whom surgical operation would be dangerous. 187 E. STATE STREET.

NARCOTIC TAX DUE

Ohio physicians are reminded that each physician wishing to prescribe or dispense narcotics must register with the collector of internal revenue of his district and pay the special federal tax of $1 on or before July 1 or lose the permit which he now holds.

Physicians are advised to refresh their memory from time to time relative to the meaning and intent of the Harrison Narcotic Law and the various regulations governing the prescribing and dispensing of narcotic drugs. Severe penalties are provided for in the regulations for violations, so each physician should make certain that he is complying in every way with the statutes and regulations.

The Journal on numerous occasions has published detailed analyses of the Harrison Law and the various regulations. Those desiring information regarding the scope of the law and regulations, how to fill out applications for permits, how to keep office records on narcotic prescriptions, etc., will find the following *Journal* articles helpful: April, 1930, issue, Pages 341 and 342; January, 1931, issue, Pages 68-70, and June, 1931, issue, Pages 500 and 501.

REPORT ON NARCOTIC WORK

A report of interest dealing with a relatively new activity of the Public Health Service has been submitted to Congress by Surgeon General H. S. Cumming. This report indicates that during the past fiscal year studies have been continued on the nature of drug addiction and the best methods of treatment and rehabilitation of persons addicted to the use of habit-forming drugs; information has been disseminated on researches in this particular field; state and local jurisdictions have been cooperating with the view to their providing facilities for the care and treatment of narcotic drug addicts. Studies have been conducted on the abusive use of narcotic drugs and the quantities of such drugs necessary to supply the normal and emergency medicinal and scientific requrements of the United States. The site for the first narcotic farm, near Lexington, Ky., was acquired during the year and plans were begun for the development of the necessary buildings to accommodate 1,000 inmates. A site for the second narcotic farm, near Fort Worth, Texas, was selected.

A memorial column to dietitians who served in the World War located in the American Red Cross Memorial Building, Washington, D. C., was recently unveiled. The column was given by the American Dietetics Association.

The House of Delegates Official Proceedings, Ohio State Medical Association, Dayton, May 3 and 4, 1932

Minutes

The Eighty-Sixth Annual Meeting of the Ohio State Medical Association convened officially in the Dayton-Biltmore Hotel, Dayton, at 9:30 A. M., Tuesday, May 3, 1932. Dr. F. K. Kislig, president of the Montgomery County Medical Society officially welcomed the Annual Meeting to Dayton. He sketched briefly the history and interest of the Dayton profession in medical organization. He referred to the previous Annual Meetings held in Dayton, and to the Dayton physicians who had served as President of the State Association in the past. Dr. A. W. Carley, general chairman of the local committees, was called on for announcements.

Dr. Houser, president of the State Association, then being presented, called the House of Delegates into official session.

Under the first order of business announced by the President, the roll call of officers and delegates showed ninety delegates and officers present, this being the majority of those registered and constituting a quorum under the Constitution. (See tabulation for roll call attendance on page 456).

On *motion* by Dr. Micklethwaite, seconded by Dr. Chamberlain and *carried*, the minutes of the House of Delegates of the 85th Annual Meeting held in Toledo, May 12 and 13, 1931, were approved as published on pages 471 to 485, inclusive, of the June, 1931, issue of *The Journal*.

Attention was called by the President to the requirement that all resolutions to be introduced later in this session must be referred to the Committee on Resolutions for consideration by the committee and transmission to the House of Delegates at the Wednesday afternoon session, thus requiring that all resolutions to be considered at this Annual Meeting must be introduced at the present session. He also announced that all resolutions must be introduced in typewritten form, in duplicate, and signed by the author.

The Annual Reports

In the order of procedure, President Houser then called for the annual reports of officers, standing committees and special committees. These reports were published in full in the May, 1932, issue of *The Journal* and were submitted, as published, for the consideration of the House of Delegates, these reports being:

Reports of Standing Committees:

(a) Public Policy—John B. Alcorn, Columbus, Chairman, pages 350 to 355.

(b) Medical Economics—J. Craig Bowman, Upper Sandusky, Chairman, pages 355 to 361.

(c) Publication—Andrews Rogers, Columbus, Chairman, pages 361 to 363.

(d) Medical Defense—J. E. Tuckerman, Cleveland, Chairman, pages 364 to 366.

(e) Medical Education and Hospitals—Ben R. McClellan, Xenia, Chairman, pages 366 to 371.

(f) Auditing and Appropriations—S. J. Goodman, Columbus, Chairman, pages 374 to 377.

Reports of Special Committees:

(a) Mental Hygiene—E. J. Emerick, Columbus, Chairman, pages 377 to 380.

(b) Periodic Health Examinations—V. C. Rowland, Cleveland, Chairman, pages 371 to 374.

(c) Military—Harry D. Jackson, Circleville, Chairman, pages 380 to 383.

Report of Officers:

(a) Treasurer's Report combined with report of Committee on Auditing and Appropriations, pages 374 to 377.

(b) Reports of Councilors as to the condition of the societies in their respective districts, pages 383 to 385.

President Houser announced that all the foregoing reports were referred at this time without discussion to the Reference Committee on Annual Reports to be announced later at this session, and for consideration and report by the Reference Committee at the Wednesday (May 4) afternoon session of the House of Delegates.

Appointment of Reference and Active Committees

The President announced the appointment of reference and active committees of the House of Delegates as follows:

Annual Addresses of the President and President-Elect—Gainor Jennings, West Milton, Chairman; Charles P. McKee, St. Marys; John P. DeWitt, Canton; E. L. Crum, Lodi; Howard Jones, Circleville.

Resolutions—H. V. Paryzek, Cleveland, Chairman; Emmet A. Moore, Newark; C. I. Stephen, Ansonia; I. B. Harris, Columbus; Harold Heffron, Metamora.

Annual Reports of Standing and Special Committees—S. V. Burley, Lorain, Chairman; Lee Humphrey, Malta; R. C. Chamberlain, Tiffin; C. W. Kirkland, Bellaire; Geo. P. Tyler, Jr., Ripley.

Credentials of Delegates—M. A. Loebell, Zanesville, Chairman; L. G. Sheets, Ashland; John Philson, Racine; Geo. DeMuth, Sherwood; G. E. Jones, Jackson.

Tellers and Judges of Election—A. O. Peters, Dayton, Chairman; J. M. King, Wellsville; E. D.

Foltz, North Baltimore; A. R. Callander, Delaware; D. M. Blizzard, Middletown.

Election of Nominating Committee

In compliance with the constitutional provisions in selecting members of the Nominating Committee, one from each of the ten councilor districts, the following personnel of such committee was nominated and duly elected:

First District—E. O. Smith, Cincinnati, nominated by Dr. Freiberg.

Second District—D. W. Hogue, Springfield, nominated by Dr. Huston.

Third District—C. K. Startzman, Bellefontaine, nominated by Dr. Bowman.

Fourth District—John F. Wright, Toledo, nominated by Dr. Lukens.

Fifth District—C. W. Stone, Cleveland, nominated by Dr. King.

Sixth District—F. C. Potter, Akron, nominated by Dr. Hoyt.

Seventh District—Albert Weinstein, Steubenville, nominated by Dr. Kirkland.

Eighth District—E. R. Brush, Zanesville, nominated by Dr. Loebell.

Ninth District—J. J. McClung, Jackson, nominated by Dr. Micklethwaite.

Tenth District—John B. Alcorn, Columbus, nominated by Dr. Thomas.

On *motion* duly seconded and *carried*, the House of Delegates elected by acclamation each of the above members nominated for the Nominating Committee.

President Houser then announced the official personnel of the Nominating Committee as elected by the House of Delegates, as follows:

First District—E. O. Smith,
Second District—D. W. Hogue,
Third District—C. K. Startzman,
Fourth District—John F. Wright,
Fifth District—C. W. Stone,
Sixth District—F. C. Potter,
Seventh District—Albert Weinstein,
Eighth District—E. R. Brush,
Ninth District—J. J. McClung,
Tenth District—John B. Alcorn.

Nominations to Be Made

The President issued instructions to the Nominating Committee, under the constitutional provisions, and requested them to meet and decide upon one nominee for each of the offices to be filled at this Annual Meeting, except for the office of president-elect, which latter office is to be upon nomination on the floor of the House of Delegates at the Wednesday afternoon session.

Introduction of Resolutions

In the next order of business, the President called for the introduction of resolutions. The following resolutions were then introduced and on *motion* duly seconded and *carried*, were each referred to the Committee on Resolutions for consideration and report at the second session of the House of Delegates.

RESOLUTION A. INTRODUCED BY F. C. POTTER, AKRON:

WHEREAS, There are pending in the Congress of the United States two bills—S. 572 and H.R. 7525—seeking appropriations on a federal subsidy basis for sanitary measures in rural communities and for revival of the Sheppard-Towner plan for maternity and infant hygiene activity, and

WHEREAS, Legislation of the character proposed in those measures has been demonstrated by the former Sheppard-Towner Act to be ineffective in reducing maternal and infant mortality and produces no benefit in any way commensurate with the amount of money expended, and

WHEREAS, Such legislation is based on unsound social and economic principles; tends to promote bureaucracy; is a duplication of the duties and functions already placed on the United States Public Health Service; would, if judged by past experience, be extravagant and unproductive of good results; is a usurpation of the rights of the individual states, and tends to destroy local initiative and responsibility, and

WHEREAS, This type of legislation, unsound in principles at any time, is especially objectionable and undesirable now because of the unsettled economic situation when the Federal Government and many state and local governments are faced with large deficits and decreased revenues, and there is a universal demand for economy in government, and

WHEREAS, Inefficient, wasteful, impractical and paternalistic legislation like S. 572 and H. R. 7525 tends to induce the states by federal bribes—euphoniously referred to as subsidies—to appropriate money and therefore to increase state taxes beyond actual needs and reasonable prospects for public benefit, or else to deprive other state activities of sufficient funds to carry on necessary work which would yield far larger returns and public benefits, therefore, be it

RESOLVED, By the House of Delegates in annual session May 3 and 4, 1932, Dayton, Ohio, that the Ohio State Medical Association express its disapproval of and opposition to the enactment of this and similar legislation for the reasons stated above, which action, however, should not be interpreted to mean that medical organization is not in entire sympathy with cooperative efforts to establish and develop official *local* and *state* health organization for the conduct of activities which are recognized as the proper functions of such departments.

FURTHER, BE IT RESOLVED that a copy of this resolution be sent to each member of the Ohio delegation in the Seventy-Second Congress.

RESOLUTION B. INTRODUCED BY H. G. SLOAN, CLEVELAND:

WHEREAS, The City of Cleveland is recognized as one of the important and outstanding medical and hospital centers of the nation, and

WHEREAS, It has been a half century since an annual session of the American Medical Association has been held in that city, and

WHEREAS, The medical profession of Cleveland, through the Academy of Medicine of Cleveland, has expressed an eager desire to entertain the

American Medical Association in 1933 and is certain that the facilities there are more than adequate to assure one of the best meetings ever held by the American Medical Association, and

WHEREAS, It would be of primary importance to the medical profession of Ohio, as well as a distinct honor, to have the 1933 meeting of our national organization held in this state, therefore, be it

RESOLVED, That we, the House of Delegates of the Ohio State Medical Association, in annual meeting May 3 and 4, 1932, Dayton, Ohio, heartily endorse the invitation of the Cleveland medical profession and pledge the interest and cooperation of the medical profession of Ohio to the Cleveland Academy of Medicine in extending such invitation to the American Medical Association.

RESOLUTION C. INTRODUCED BY GAINOR JENNINGS, WEST MILTON:

WHEREAS, The nation-wide suffering during the past two and a half years, has demonstrated to us all, that radical economic legislation should be enacted to remedy such wrongs as may be proven to exist, and it is well known, that the lack of adequate compulsory health insurance in this state is among such wrongs. ("Sickness is a factor in six and a half times as much dependency as is industrial accident.") Yet, the State requires insurance against industrial accident, but not yet against sickness—a more urgent need. Therefore, be it

RESOLVED, By the House of Delegates that the Ohio State Medical Association recommends that a law be enacted by the General Assembly of the State of Ohio, to establish a system of health insurance for employees and dependent members of their families, and providing for its administration.

RESOLUTION D. INTRODUCED BY JOHN F. WRIGHT, TOLEDO:

WHEREAS, Present events and developments indicate that the forthcoming 1933 session of the Ohio General Assembly will be one of the most crucial and far-reaching in effect ever held by the state legislature because of the vital social and economic questions which it will be called upon to consider, incident to the present period of unrest, both social and economic, and,

WHEREAS, It is probable that tremendous pressure will be brought to bear on members of the legislature by radicals, agitators and theorists for the enactment of dangerous, special-privilege, socialistic and fallacious measures of all descriptions, and for radical revision of many existing statutes, and,

WHEREAS, Many of these anticipated proposals would establish unsound and artificial panaceas to correct temporary social and economic imbalances; others would add new governmental functions and create additional bureaus, departments and services, thus adding to the cost of government and curtailing to a still greater extent local responsibility and individual initiative and enterprise; and, still others would nullify or destroy present laws which have proved beneficial to public health and have acted as a safeguard against cultism and quackery, and

WHEREAS, Any legislation which affects public health; tends to modify in any way the practice of medicine, and affects the social and economic status of the individual physician is of vital concern to medical organization, representing the medical profession of Ohio, therefore, be it

RESOLVED, That the Ohio State Medical Association, in annual session May 3 and 4, 1932, at Dayton, Ohio, re-emphasize and re-endorse the established and fundamentally-sound policies of medical organization of Ohio toward all legislation affecting public health, scientific medicine, medical practice, and the individual medical practitioner, namely:

(1) The medical profession of Ohio is opposed to the enactment of any legislation which would be detrimental to the health of the citizens of the state; which would hinder or prevent effective public health administration, and which would cripple the present public health code in such a way that the welfare and the best interests of the citizenry would be endangered;

(2) The medical profession of Ohio condemns and opposes those proposals which would interfere with the advancement of scientific medicine; lower the high standards surrounding medical practice in Ohio, and jeopardize the health and welfare of the people by extending legal privileges to unqualified, incompetent and untrained individuals;

(3) The medical profession of Ohio disapproves the enactment of paternalistic, socialistic and communistic legislation, believing it to be contrary to sound economic and social principles and adverse to good government; and, especially sosialistic proposals which would place the state in a position of competing with the individual physician or would interfere with the status of the medical profession as an individual, competitive professional calling.

BE IT FURTHER RESOLVED, That it is the sentiment of this Association that each of its members should deem it his obligation and responsibility to take an active, personal interest in moulding public opinion in accordance with the foregoing principles, and, as an influential citizen of his community, aid in selecting for public office—national, state and local—persons who can be depended upon to protect and further the best interests of the public generally, and who will look to the medical profession for counsel and advice on those matters pertaining to public health, medical practice and scientific medicine, it being the most competent and best informed to render such advice and information.

RESOLUTION E. INTRODUCED BY E. R. BRUSH, ZANESVILLE:

WHEREAS, Present state and national statues restrict the quantity of medicinal liquor a physician may prescribe or administer to any one patient within a stated period, and

WHEREAS, Such statutory restrictions deprive the physician of his right to the free exercise of his judgment in the practice of his profession and prevent him from employing medicinal liquor in such doses as are, in his honest scientific judgment, therapeutically indicated and beneficial to his patients, and

WHEREAS, It is unwise and dangerous to the public health and welfare for legislative bodies, composed of laymen, to undertake through legislative fiat to restrict the administration of any therapeutic agent by physicians legally qualified to practice medicine and the most competent to judge what therapeutic means should be undertaken in the treatment of diseases and ailments, and

WHEREAS, There are at present pending in the Congress of the United States two identical measures—S. 3090 and H. R. 10524—sponsored by the American Medical Association, which would remove the quantitative limits from existing

statutes governing the prescribing of medicinal liquor by physicians, therefore, be it

RESOLVED, By the House of Delegates of the Ohio State Medical Association in annual session, May 3 and 4, 1932, at Dayton, Ohio, that this Association reiterate its approval of the principle that the dosage of a medicine should not be fixed by legislative fiat; endorse the above-named corrective measures, and urge their enactment, with proper safeguards, at the present session of Congress.

BE IT FURTHER RESOLVED, That a copy of this resolution be sent to each member of the Ohio Congressional delegation and to the members of the Senate Judiciary Committee before which these bills are pending.

RESOLUTION F. INTRODUCED BY C. W. STONE, CLEVELAND:

WHEREAS, The World War Veterans' Act of 1924, Sub-Section 10 of Section 202 provides, under certain procedure, for the hospitalization, medical and surgical service, and necessary traveling expenses to veterans of any war, military occupation or military expedition since 1897, not dishonorably discharged, *without regard to the nature or origin of their disabilities*, and

WHEREAS, Under the terms of that Act, a gradually increasing number of beneficiaries may be provided with hospital care, medical and surgical treatment at government expense, for diseases and injuries arising from civilian life and in no way connected with military service, and

WHEREAS, A plan has been proposed to halt the building of additional federal hospitals, except for neuropsychiatric and tuberculous cases, and to arrange for the medical treatment and hospitalization of veterans locally for non-service disabilities, and

WHEREAS, The first concern of the American people should be for adequate and thorough benefits to those veterans disabled through military service, and to the dependents of those who gave their lives in service to their country, and

WHEREAS, The present program of benefits may discriminate against the veterans and their dependents whose losses were incurred in military service, therefore be it

RESOLVED, That, the House of Delegates of the Ohio State Medical Association at its annual meeting in Dayton, Ohio, May 3 and 4, 1932, reaffirms its established policy that adequate provision should be made for those whose physical disabilities were incurred in or resulted from military service, and for the dependents of those who sacrificed their lives in the service of their country; but that we reiterate our opposition to a governmental or subsidized plan which would provide medical, surgical or hospital care to all ex-service men for non-service connected disabilities or injuries, and

FURTHER BE IT RESOLVED, That the President of the Ohio State Medical Association appoint a special committee to cooperate with the American Legion, Department of Ohio, in an endeavor to formulate the most beneficial program for the ex-service men and the American people.

RESOLUTION G. INTRODUCED BY O. P. KLOTZ, FINDLAY:

WHEREAS, At the 86th Annual meeting of the Ohio State Medical Association, there has been inaugurated a scientific exhibit, and

WHEREAS, A number of our members have contributed greatly of their talents, time and efforts toward this desirable feature, therefore, be it

RESOLVED, That the House of Delegates express appreciation to the exhibitors and to the Committee on Scientific Exhibits under the chairmanship of Dr. Walter M. Simpson, and

BE IT FURTHER RESOLVED, That the account of this Annual Meeting, at Dayton, Ohio, May 3 and 4, 1932, published in the *Ohio State Medical Journal* carry special mention of the individual scientific exhibitors, and the institutions they represent.

Adoption of Amendments

Upon request of the President, the Committee of Tellers distributed to the delegates reprints of proposed and pending amendments to the Constitution and By-Laws of the Ohio State Medical Association as published in the March issue of the *Ohio State Medical Journal.*

Proposed Amendment No. 1

Dr. Cummer, the author of the amendments listed under proposed amendment No. 1, which would provide for the enlargement of the Council of the State Association by the election of four councilors-at-large, expressed his purpose in submitting the amendment. He explained, however, that in view of the importance of this question and having in mind the other suggestions for enlargement or reconstructon of the Council under some other type of amendments, it would be best to defer action at this time, giving the members of the House of Delegates, and the membership generally, further opportunity for consideration, and that amendments on the subject, of this or a similar nature, might be proposed and considered at the next annual session.

Upon *motion* by Dr. Cummer, seconded by Dr. Micklethwaite, and *carried*, this series of amendments (proposed amendment No. 1) were withdrawn by the House of Delegates from consideration.

Proposed Amendment No. 2

Amendments proposed by Dr. Caldwell and submitted for consideration by the Council were then considered to repeal Chapter III of the present By-Laws of the Ohio State Medical Association, and enact a new Chapter to provide more flexibility from time to time in the scientific programs and to permit more ready adjustment to the wishes of the membership. This amendment repeals the present provision for the six definite scientific sections which are required to meet twice during each annual meeting, and permits the Council Program Committee, upon approval of the Council, to rearrange sections or provide for more general sessions.

This amendment, upon *motion* by Dr. Goodman, seconded by Dr. Lukens, was *adopted* by the Council, and reads as follows:

Chapter III of the By-Laws

Section 1. SCIENTIFIC PROGRAM. The Scientific Assembly shall meet in one or more general sessions during each Annual Meeting, as determined by the Program Committee of

Council upon approval by Council. The Scientific Assembly shall also be divided by the Council into sections for each annual meeting.

Sec. 2. SCIENTIFIC SUBJECTS. In arranging for Section meetings, the Council shall have in mind the divisions of medicine, surgery, gynecology, obstetrics, pediatrics, eye, ear, nose and throat, neurology, psychiatry, public health, preventive medicine, and industrial medicine; and such other special fields of medicine as it may determine from time to time.

Sec. 3. SECTION OFFICERS. Each Section shall elect a chairman and a secretary to serve for the ensuing year. They shall constitute its program committee. In case a Section has not met at the preceding annual meeting or has been newly organized, or for any other reason has not elected its officers, then such officers shall be appointed by the Council.

Sec. 4. SECTION SESSIONS. Each Section shall hold its session or sessions at such time as the Council shall direct, but no more than six Sections shall meet at the same time, nor shall any Section session be allowed to conflict with a general session.

Sec. 5. TITLE OF PAPERS. No paper shall be presented before a section unless the title and an abstract which shall contain not less than thirty nor more than one hundred and fifty word is in the hands of the Program Committee at least sixty days before the first day of the annual meeting.

Sec. 6. SECTION RULES. The discussions in Sections shall be limited to scientific subjects. Rules adopted by Sections shall be subject to approval by the Council and shall not be in conflict with the Constitution and By-Laws of this Association.

Proposed Amendment No. 3

Proposed amendment No. 3 submitted by the President, Dr. Houser, would repeal the words "two months" in Section 1 of Article XI of the Constituton, and the same words in Section 1, Chapter XIII of the By-Laws, and insert in lieu thereof, the words "one month"; thus permitting a shorter time to elapse before the annual meeting during which amendments may be proposed to the Constitution and By-Laws, published in *The Journal*, and sent officially to the component societies.

Upon *motion* by Dr. Kirkland, seconded by Dr. DeWitt and *carried*, these amendments were adopted.

Proposed Amendment No. 4

This amendment submitted by the President, Dr. Houser, will make Section 4 of Chapter V of the By-Laws conform to Section 4, Chapter VIII of the By-Laws, and provide that questions of an ethical nature brought before the House of Delegates shall be referred to the Council without discussion.

Upon *motion* by Dr. Jennings, seconded by Dr. Peters and *carried*, the House of Delegates adopted this amendment, thus causing Section 4 of Chapter V of the By-Laws to read as follows:

Sec. 4. COMMITTEES OF THE HOUSE OF DELEGATES. From among members of the House of Delegates the President, for the purpose of expediting proceedings, shall appoint Reference Committees as follows: On Annual Reports; on Annual Addresses; on Resolutions; to which shall be referred all resolutions (except questions of an ethical nature involving professional relations which shall be referred to the Council without discussion); a Committee on Credentials; Tellers and Judges of Election, and other committees considered by him to be necessary.

Proposed Amendment No. 5

This proposal submitted by the President, amends Section 12 and Section 14 of Chapter XII and provides uniformity in the selection of delegates and legislative committeemen at the annual meeting of component societies.

Upon *motion* by Dr. Wills, seconded by Dr. Callander and *carried*, the House of Delegates adopted this amendment, causing Section 12 and Section 14 of Chapter XII of the By-Laws to read as follows:

Sec. 12. CERTIFICATION OF DELEGATES. At the regular annual meeting of each component county society, it shall elect delegates to represent it in the House of Delegates of this Association, in accordance with Chapter V, Section 2, of these By-Laws, unless other definite procedure for the selection of delegates is provided in the Constitution and By-Laws of such component county society or academy of medicine. The secretary of each county society shall send a list of such delegates and alternates to the Executive Secretary of this Association at least thirty days before the annual meeting. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions. In the absence of, or the disability or disqualifying of a delegate, his duly certified alternate may be seated in his place.

Sec. 14. AUXILIARY LEGISLATIVE COMMITTEE. At the reglar annual meeting of each component county society, it shall elect one of its members as a member of the auxiliary committee on Public Policy, unless other definite procedure for the selection of such committeeman is provided in the Constitution and By-Laws of such component county society or academy of medicine, and the county society secretary shall send his name and address at once to the Executive Secretary of The Ohio State Medical Association. The committee on Public Policy of The Ohio State Medical Association shall formulate the duties of this auxiliary committee and supply each member with a copy. The auxiliary committeemen shall be accountable to their county societies and to the Council of The Ohio State Medical Association for prompt response to and continued cooperation with the State Association Committee on Public Policy.

Proposed Amendment No. 6

This proposal by Dr. King would amend Section 4 of Chapter I of the By-Laws by eliminating the present requirement that an applicant for membership be a citizen or have taken out first citizenship papers.

Following discussion on being put to vote, this proposed amendment was *lost*.

Miscellaneous Business

Announcements were made by the chairmen of the various reference committees of the time and meeting places for their respective committees, in order that members of the House of Delegates and other members interested in matters referred to such committees, might appear at such meetings.

Additional business was called for and there being none presented, the House of Delegates adjourned to meet in the same room, Dayton-Biltmore Hotel, at 3.30 P.M., on the following day, May 4, 1932.

Second Session

The second and final session of the House of Delegates during the Eighty-Sixth Annual Meeting was called to order by President Houser at 3:30 P.M., Wednesday, May 4, 1932, in the Dayton-Biltmore Hotel.

Responses to the roll call showed ninety-two delegates and officers present (for tabulation, see page 456).

Annual Election

The next order of business being nominations from the floor for president-elect, nominations were called for. Dr. DeWitt placed in nomination for the office of president-elect, Dr. Clyde L.

Cummer of Cleveland, and called attention to his many years of devoted service to scientific medicine, medical organization and public affairs. This nomination was seconded by Dr. Upham, Dr. Houghtaling and Dr. Burley. Further nominations being called for, and none being made, on *motion* by Dr. Jennings, seconded by Dr. Peters and *carried*, the nominations were closed and the secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Clyde L. Cummer of Cleveland, as president-elect of the Ohio State Medical Association. So recorded and announced.

The President then called upon and introduced Dr. Cummer, who, in well chosen but brief remarks, expressed his humility in facing the responsibilities of the position, urged that members be encouraged to submit their suggestions to the officers at all times and pointed out that "we are all doctors, all brothers and all together."

Election of Councilors

Under the next order of business, the Nominating Committee was requested to report, and through Dr. Smith, the Chairman, nominees for the office of Councilor from the First, Third, Fifth, Seventh and Ninth Councilor Districts were submitted.

First District Councilor Election

The Nominating Committee announced the following nomination for Councilor from the First District:—John A. Caldwell, Cincinnati.

There being no further nominations from the floor, on *motion* by Dr. Seibert, seconded by Dr. Greenebaum and *carried*, the secretary was instructed to cast the unanimous ballot of the House of Delegates for John A. Caldwell, Cincinnati, for Councilor of the First District for the constitutional term of two years. So recorded and announced.

Third District Councilor Election

The Nominating Committee announced the following nomination for Councilor from the Third District:—O. P. Klotz, Findlay.

There being no further nominations from the floor, on *motion* by Dr. Rank, seconded by Dr. McDougall and *carried*, the secretary was instructed to cast the unanimous ballot of the House of Delegates for O. P. Klotz, Findlay, for Councilor of the Third District for the constitutonal term of two years. So recorded and announced.

Fifth District Councilor Election

The Nominating Committee announced the following nomination for Councilor from the Fifth District:—H. V. Paryzek, Cleveland.

There being no further nominations from the floor, on *motion* by Dr. Wright, seconded by Dr. Stone and *carried*, the secretary was instructed to cast the unanimous ballot of the House of Delegates for H. V. Paryzek, Cleveland, for Councilor of the Fifth District for the constitutional term of two years. So recorded and announced.

Seventh District Councilor Election

The Nominating Committee announced the following nomination for Councilor from the Seventh District:—E. B. Shanley, New Philadelphia.

There being no further nominations from the floor, on *motion* by Dr. Kirkland, seconded by Dr. McDoungall and *carried*, the secretary was instructed to cast the unanimous ballot of the House of Delegates for E. B. Shanley, New Philadelphia, for Councilor of the Seventh District for the constitutonal term of two years. So recorded and announced.

Ninth District Councilor Election

The Nominating Committee announced the following nomination for Councilor from the Ninth District:—I. P. Seiler, Piketon.

There being no further nominations from the floor, on *motion* by Dr. Tatman, seconded by Dr. Rank and *carried*, the secretary was instructed to cast the unanimous ballot of the House of Delegates for I. P. Seiler, Piketon, for Councilor of the Ninth District for the constitutonal term of two years. So recorded and announced.

Election of A. M. A. Delegates

The Nominating Committee, through Dr. Smith, chairman, announced the nomination of the following delegates and alternates to the American Medical Association for a term of two years:

Wells Teachnor, Sr., Columbus, Delegate
D. H. Morgan, Akron, Alternate
Ben R. McClellan, Xenia, Delegate
A. C. Messenger, Xenia, Alternate
E. R. Brush, Zanesville, Delegate
A. Howard Smith, Marietta, Alternate
C. W. Stone, Cleveland, Delegate
C. L. Cummer, Cleveland, Alternate

There being no nominations from the floor, on *motion* by Dr. Tuckerman, seconded by Dr. Alcorn and *carried*, the secretary was instructed to cast the unanimous ballot of the House of Delegates for the nominations as made by the Nominating Committee. So recorded and announced.

Reports of Reference Committees

The next order of business being the reports of the various committees appointed by the President at the first session of the House of Delegates, Dr. Jennings presented the report of the Committee on Addresses of the President and President-Elect.

Annual Addresses

The Address of Dr. H. M. Platter

The address of the incoming President reminds us that in the early part of the last century but 10 per cent of the medical practitioners in the country were graduates of a medical school, and that the present-day requirement is at least two colle-

OHIO STATE MEDICAL ASSOCIATION

Officers 1932-1933

PRESIDENT

H. M. Platter, M.D. ..... Columbus

PRESIDENT-ELECT

C. L. Cummer, M.D. ..... Cleveland

TREASURER

James A. Beer, M.D. ..... Columbus

EXECUTIVE SECRETARY

Don K. Martin ..... Columbus

State Council

FIRST DISTRICT

John A. Caldwell, M.D. ..... Cincinnati

SECOND DISTRICT

E. M. Huston, M.D. ..... Dayton

THIRD DISTRICT

O. P. Klotz, M.D. ..... Findlay

FOURTH DISTRICT

B. J. Hein, M.D. ..... Toledo

FIFTH DISTRICT

H. V. Paryzek, M.D. ..... Cleveland

SIXTH DISTRICT

H. S. Davidson, M.D. ..... Akron

SEVENTH DISTRICT

E. B. Shanley, M.D. ..... New Philadelphia

EIGHTH DISTRICT

E. R. Brush, M.D. ..... Zanesville

NINTH DISTRICT

I. P. Seiler, M.D. ..... Piketon

TENTH DISTRICT

S. J. Goodman, M.D. ..... Columbus

EX-OFFICIO, THE EX-PRESIDENT

D. C. Houser, M.D. ..... Urbana

STANDING COMMITTEES (Constitutional)

PUBLIC POLICY

John B. Alcorn, Chairman, (1933) ..... Columbus
J. H. J. Upham, (1934) ..... Columbus
C. W. Stone, (1935) ..... Cleveland
H. M. Platter, (ex-officio) ..... Columbus
C. L. Cummer, (ex-officio) ..... Cleveland

PUBLICATION

Andrews Rogers, Chairman, (1934) ..... Columbus
A. B. Denison, (1933) ..... Cleveland
Gilbert Micklethwaite, (1935) ..... Portsmouth

MEDICAL DEFENSE

J. E. Tuckerman, Chairman, (1934) ..... Cleveland
W. H. Snyder, (1933) ..... Toledo
F. P. Anzinger, (1935) ..... Springfield

MEDICAL EDUCATION AND HOSPITALS

Ben R. McClellan, Chairman, (1934) ..... Xenia
John F. Wright, (1933) ..... Toledo
R. H. Birge, (1935) ..... Cleveland

MEDICAL ECONOMICS

J. Craig Bowman, Chairman, (1933) ..... Upper Sandusky
A. B. Brower, (1934) ..... Dayton
E. O. Smith, (1935) ..... Cincinnati

SECTION OFFICERS FOR 1932-1933

MEDICINE

Carll S. Mundy ..... Chairman
125 15th St., Toledo
Cecil Striker ..... Secretary
700 Provident Bank Bldg., Cincinnati

SURGERY

M. E. Blahd ..... Chairman
1420 Medical Arts Bldg., Cleveland
Norris Gillette ..... Secretary
320 Michigan St., Toledo

OBSTETRICS AND PEDIATRICS

B. H. Carroll ..... Chairman
240 Michigan St., Toledo
Edward A. Wagner ..... Secretary
2560 Grandin Rd., Cincinnati

EYE, EAR, NOSE AND THROAT

W. V. Mullin ..... Chairman
Euclid at 93rd St., Cleveland
Ivor G. Clark ..... Secretary
188 E. State St., Columbus

NERVOUS AND MENTAL DISEASES

J. Fremont Bateman ..... Chairman
Box 36, Elmwood Place
Henry C. Schumacher ..... Secretary
2525 Euclid Ave., Cleveland

PUBLIC HEALTH AND INDUSTRIAL MEDICINE

R. H. Markwith ..... Chairman
Court House Annex, Akron
P. A. Davis ..... Secretary
1004 E. Market St., Akron

Delegates and Alternates to American Medical Association

DELEGATES		ALTERNATES	
J. P. DeWitt, (1933)	Canton	G. F. Zinninger, (1933)	Canton
C. E. Kiely, (1933)	Cincinnati	L. H. Schriver, (1933)	Cincinnati
C. W. Waggoner, (1933)	Toledo	John Sprague, (1933)	Athens
Wells Teachnor, Sr., (1934)	Columbus	D. H. Morgan, (1934)	Akron
Ben R. McClellan, (1934)	Xenia	A. C. Messenger, (1934)	Xenia
E. R. Brush, (1934)	Zanesville	A. Howard Smith, (1934)	Cincinnati
C. W. Stone (1934)	Cleveland	C. L. Cummer, (1934)	Cleveland

giate years and four years in an accredited school; and the passing of an examination by the State Medical Board.

Our President-elect manifests a firm faith in the uprightness and sincerity of our profession, which has been true to its ideals. Our State Medical Organization, he believes, has been, and is, a great stimulus to advancing thought and creative effort. He admits that perhaps few of our members have elected to worship Mammon (but we from the county organizations will admit that we would not recognize Mammon if we met that god in the middle of the highway).

We are pleased that he recognizes the importance of the county medical societies and gives to these many deserved commendatory comments. He encourages the idea of a definite leadership which can and should be developed.

We are glad to hear his remarks on non-medical assistants in hospitals, laboratories, the public health field and other activities. We agree with his declaration that: "Local medical organizations must assume leadership in these activities. Medicine must remain an individual activity, limited in its practice and performance by the provision of our code."

There is no doubt in the mind of this committee that the coming year will bring to light new and interesting problems requiring solution, and that our incoming President will bring to his work a great enthusiasm and an unquenchable desire to continue the achievements of which our profession is so justly proud.

The Address of Dr. D. C. Houser

Dr. Houser, our retiring President, realizes the immensity of a president's duties.

It is interesting to note how he stresses the services rendered by physicians and how their services influence the destinies of communities and the Nation. He deplores the fact that so many social welfare movements and the increasing functions of government directly impinge upon medical practice.

His statistics regarding the disposal of the national income were startling and specially so the mention of Federal agencies concerned with health legislation.

The committee feels that too great attention cannot be paid to the valuable information he submits regarding voluntary health-welfare organizations and the encroachment on the practice of medicine by private philanthropists. We are distressed in the fact that free clinics and free hospitals are growing like mushrooms—far outdistancing the needs of the poor and the inclusion of service to patients who can afford to pay. The fact that nearly nine million patients will be treated this year in free clinics is startling information and the large sums of money spent on buildings, personnel, etc., do not include the physician whose service is the vital commodity and who is denied any voice in the management.

Dr. Houser calls attention to the stand taken several years ago by the House of Delegates concerning "state medicine" and "socialized medicine"; and all physicians would do well to absorb his comment in which he clearly points out the fundamental harmony between medical practice and public health when the latter is properly defined and limited.

We agree that public health's prime duties are sanitation and the control of communicable disease through quarantine, and perhaps more important, immunization.

His statement that public health at the present time is taking on new jobs before the old have been satisfactorily completed meets with our hearty agreement. We agree with him that any public clinic conducted by health agencies should be restricted to educational purposes and should be held only under the direction and supervision, or with the official approval of the local county medical society or academy of medicine.

His comments upon the county units were most constructive and stimulating to all of us and we owe Dr. Houser a vote of thanks for his appreciation of the county unit in our organization, which cannot always successfully function on problems of state-wide nature.

We fully agree with the outgoing President that medicine, if it fulfils its function, must be a structure of cooperation.

The committee suggests that our State Association officials assume power to preserve the thought and advice which Dr. Houser has brought to us, by calling the attention of the county society officers to this splendid address and to request them to convey this information to the attention of their members; and also to inform the thinking public of the dangers, complexities and immensity of movements and agencies tending to socialize medical practice, interfere with scientific medicine and exploit unsound theories in public health programs.

This address indicates the untiring service rendered by Dr. Houser, his faithfulness to his duties and the great sacrifice of time and effort he has made in our behalf in attendance at numerous medical meetings throughout the state, his participation in each meeting of our State Association committees and in conference with representatives of many groups interested in our common problems.

In recommending approval of his address, we also suggest appreciation for his outstanding service.

(Signed) GAINOR JENNINGS, Chairman,
E. L. CRUM,
JOHN P. DEWITT,
CHAS. P. MCKEE,
HOWARD JONES.

On *motion* by Dr. Upham, seconded by Dr. Emerick and *carried*, the above report was accepted, approved and adopted.

Annual Reports

TO THE HOUSE OF DELEGATES OF THE OHIO STATE MEDICAL ASSOCIATION:

Your committee on Annual Reports of Standing and Special Committees has the honor to report the following:

I. Annual Report of the *Committee on Public Policy.*

The committee has this year, as in former years, followed closely all developments affecting policy, governmental administration and the activities of groups and agencies concerned with public health and medical practice. Problems of ethics and professional relations, as well as the many legislative proposals in which the medical profession was interested. The committee has endeavored to present the medical viewpoint on these issues, and has kept the membership properly informed on such developments and activities. Careful attention also has been paid to federal as well as state questions. Careful study has been devoted to problems arising from the administration of the World War Veterans' Act, and to legislative proposals in connection with the government's medical and hospitalization program for ex-service

men. The committee is to be highly commended for its activity, and deserves the cooperation of the membership at large.

II. The Annual Report of the *Committee on Medical Economics.*

This committee has brought out in its report the increasing perplexities of this period of economic and social unrest. Many details have been covered in this report, but to fully appreciate it, each member should read the report carefully.

III. Annual Report of the *Committee on Publication.*

In reviewing the annual report of the Publication Committee, only highest commendation can be given to the work done. Cooperation of every member of the Association is a keynote to a successful Journal.

IV. Annual Report of *Committee on Medical Defense.*

The work of this committee has been studied and is to be commended. The fundamental regulations of the medical defense plan have been set forth in the report and the procedure should be carried out in case defense is needed. All copies of these reports can easily be obtained from the Executive Secretary of the Ohio State Medical Association.

V. Annual report of the *Committee on Medical Education and Hospitals.*

The report of this committee has been reviewed and the following short summary submitted:

Special training in the basic principles of medical education.

More time be spent in preparing students entering the field of specialties and frequent postgraduate courses for the men in general practice.

Your committee further suggests that more time be given to the teaching of social and economic subjects as pertaining to medicine.

VI. Annual Report of the *Committee on Periodic Health Examinations.*

The committee has endeavored to point out in a general way the necessity of interesting the profession itself in periodic health examinations to simplify the ordinary routine physical examination as much as possible, and no attempt made to standardize fees; but each examination be as elaborate as the condition of the patient indicates; special tests being made when necessary. Furthermore, we recommend that each county society devote one meeting per year to the study of health examinations.

VIII. Anuual Report of *Committee on Auditing and Appropriations.*

This report shows that the sound financial condition of the society has been maintained, and that with the funds available, the income derived and amount expended, medical organization in Ohio has accomplished more and has been of greater service to its membership on nominal dues than any similar organization elsewhere.

VIII. Annual Report of *Committee on Mental Hygiene.*

This committee has made important progress during the past year. Elaborate study has been made and an analysis presented of the housing and care of the State's insane and mentally deficient. Further study will be necessary to estimate how much expansion is needed at all institutions so as not to handicap mental activities. The Association should do all in its power and cooperate fully with this very important committee.

IX. Annual Report of *Committee on Military Affairs.*

The annual report of the Committee on Military Affairs was submitted showing the distribution of the various units of the Reserve Corps in Ohio, and an appreciable gain shown in the Medical Department of Reserve Officers in Ohio. Procurement of eligible medical personnel has been carried on as in other years, with special emphasis placed on contact with recent graduates.

X. *Annual Report of Councilors.*

A brief report which merely outlines the work of the officers and Council of this organization has been submitted, setting forth the aims and ideals that have guided these men in the administration of our affairs. Your reference committee wishes to thank the officers and Council, and assure them of the support of this Association. The Committee has been impressed with the fact that these reports of the standing and special committees show a deep interest in the problems of medical organization in this state, and at this time to commend our Executive Secretary, Don K. Martin, for his advice and judgment to the officers and various committeemen.

In conclusion we recommend that the House of Delegates extend their appreciation to the Council and to the standing and special committees for their work during the past year.

(Signed) S. V. BURLEY, *Chairman,*
LEE HUMPHREY,
R. C. CHAMBERLAIN,
C. W. KIRKLAND.

On *motion* by Dr. Jennings, seconded by Dr. Souders and *carried*, the above report by sections and in its entirety was accepted, approved and *adopted.*

Report of Committee on Resolutions

Dr. Paryzek, the Chairman, on behalf of the Committee on Resolutions, presented the following:

To the House of Delegates,
Ohio State Medical Association, at the 86th annual meeting, Dayton, Ohio.

Your Committee on Resolutions comprising I. B. Harris, Columbus; Emmet A. Moore, Newark; C. I. Stephen, Ansonia; and Harry V. Paryzek, Cleveland, desires to submit the following unanimous report concerning the seven resolutions introduced at the first session of the House of Delegates, May 3, 1932.

RESOLUTION A

Introduced by F. C. Potter (Summit County). Expresses its disapproval of two bills pending in the Congress of the United States, seeking federal subsidy for sanitary measures in rural communities, and for the revival of the Sheppard-Towner plan for maternity and child welfare. While the Committee agrees with the major intent of the resolution, it believes that the resolution as presented contains many repetitions, and voices a critical attitude which would tend to detract from the force of the issue.

Your Committee, therefore, approves of the following revised resolution, and recommends its

adoption by the House of Delegates. It reads as follows:

WHEREAS, There are pending in the Congress of the United States two bills—S. 572 and H. R. 7525—designed to provide federal subsidy for sanitary measures in rural communities and for the revival of the Sheppard-Towner plan for maternity and child welfare, and

WHEREAS, Such legislation is based on unsound social and economic principles; tends to promote bureaucracy; duplicates the duties and functions of the United States Public Health Service; and would, if judged by past experience, be extravagant and unproductive of good results; would usurp the rights of the individual states, and tend to destroy local initiative and responsibility, and

WHEREAS, This type of legislation is especially undesirable during the present unsettled economic situation of the Federal Government and many state and local governments, and

WHEREAS, Medical organization has always been in sympathy with cooperative efforts to establish and develop proper local and state health organization for the conduct of activities which are recognized as the proper functions of such departments, therefore be it

BE IT RESOLVED, By the House of Delegates in the annual session, May 3 and 4, at Dayton, Ohio, that the Ohio State Medical Association express its disapproval of, and opposition to, the enactment of this and similar legislation, and be it further

RESOLVED, That a copy of this resolution be sent to each member of the Ohio Delegation in the Seventy-Second Congress.

On *motion* by Dr. Paryzek, seconded by Dr. Tuckerman, and *carried*, Resolution A was accepted, approved and *adopted*.

RESOLUTION B

Introduced by Harry G. Sloan (Cuyahoga County), is an invitation extended by the Academy of Medicine of Cleveland for the American Medical Association to hold its annual meeting in Cleveland in 1933. Your Committee fully appreciates the spirit which prompts the Academy of Medicine of Cleveland to entertain our national organization, and, therefore, recommends the approval of this resolution by the House of Delegates. It reads as follows:

WHEREAS, The City of Cleveland is recognized as one of the important and outstanding medical and hospital centers of the nation, and

WHEREAS, It has been a half century since an annual session of the American Medical Association has been held in that city, and

WHEREAS, The medical profession of Cleveland, through the Academy of Medicine, has expressed an eager desire to entertain the American Medical Association in 1933 and is certain that the facilities there are more than adequate to assure one of the best meetings ever held by the American Medical Association, and

WHEREAS, It would be of primary importance to the medical profession of Ohio, as well as a distinct honor, to have the 1933 meeting of our national organization held in this state, therefore, be it

RESOLVED, That we, the House of Delegates of the Ohio State Medical Association, in annual meeting, May 3 and 4, 1932, Dayton, Ohio, heartily endorse the invitation of the Cleveland medical profession and pledge the interest and cooperation of the medical profession of Ohio to the Cleveland Academy of Medicine in extending such invitation to the Americal Medical Association.

On *motion* by Dr. Paryzek, seconded by Dr. Sloan, and *carried*, Resolution B was accepted, approved and *adopted*.

RESOLUTION C

Introduced by Gainor Jennings (Miami County) and read by C. C. McLean (Montgomery County), recommends the enactment of compulsory health insurance in the State of Ohio.

Your Committee is emphatic in its disapproval of such legislation, since it would advocate a radical reversal of policy on the part of the Ohio State Medical Association.

Accordingly, your Committee recommends that this resolution be rejected.

In voicing the disapproval of this resolution, your Committee desires to call your attention to another resolution (D) introduced by J. F. Wright (Lucas County) which we believe represents the overwhelming and well-considered opinion of the membership.

On *motion* by Dr. Paryzek, seconded by Dr. McDougall and *carried*, the foregoing recommendation *for rejection of Resolution C* was passed.

RESOLUTION D

Introduced by J. F. Wright (Lucas County) reiterates and re-emphasizes the established and fundamental policies of medical organization of Ohio toward public health legislation, scientific medicine and medical practice.

Your Committee is favorably impressed with the endorsement of the sound principles as expressed in this resolution, and believes that the adherence to a conservative and firm policy is desirable, particularly during a period of social and economic unrest.

Furthermore, your Committee is of the opinion that this resolution can be modified without materally altering its purpose and, therefore, recommends the following revised resolution for adoption by the House of Delegates. This resolution reads as follows:

WHEREAS, Present events and developments indicate that the forthcoming 1933 session of the Ohio General Assembly will be one of the most crucial and far-reaching in effect ever held by the State Legislature, and

WHEREAS, It is probable that tremendous pressure will be brought to bear by radicals, agitators and theorists for the enactment of dangerous, special-privilege, socialistic and fallacious measures, and for medical revision of many existing statutes, therefore, be it

RESOLVED, That the Ohio State Medical Association, in annual session May 3 and 4, 1932, at Dayton, Ohio, re-emphasize and re-endorse the

established and fundamentally-sound policies of medical organization of Ohio toward all legislation affecting public health, scientific medicine and medical practice, namely:

(1) The medical profession of Ohio is opposed to the enactment of any legislation which would be detrimental to the health of the citizens of the State or which would hinder or prevent effective public health administration;

(2) The medical profession of Ohio condemns and opposes those proposals which would interfere with the advancement of scientific medicine; lower the high standards surrounding medical practice in Ohio, and jeopardize the health and welfare of the people by extending legal privileges to unqualified, incompetent and untrained individuals;

(3) The medical profession of Ohio disapproves the enactment of paternalistic, socialistic and communistic legislation, especially socialistic proposals which would interfere with the status of the medical profession as an individual competitive professional calling, be it further

RESOLVED, That it is the sentiment of this Association that each of its members should deem it his obligation and responsibility to take an active, personal interest in moulding public opinion in accordance with the foregoing principles, and, as an influential citizen of his community, aid in selecting for public office—national, state and local—persons who can be depended upon to protect and further the best interests of the public generally, and who will look to the medical profession for counsel and advice on those matters pertaining to public health, medical practice and scientific medicine.

On *motion* by Dr. Paryzek, seconded by Dr. Chaney and *carried*, Resolution D was accepted, approved and *adopted.*

RESOLUTION E

Introduced by E. R. Brush (Muskingum County) disapproves of statutory regulations which restrict the quantity of medical liquor a physician may prescribe or administer, and endorses the two bills sponsored by the American Medical Association which propose to remove the quantitative limit from existing statutes governing the prescribing of medicinal liquor by physicians.

Your Committee is of the opinion that this resolution would more accurately express our professional position if it defined the right of the physician to the free exercise of his judgment in the practice of his profession, and endorsed the two bills sponsored by the American Medical Association at present pending in the Congress of the United States.

Therefore, the Committee recommends the following revised resolution for adoption by the House of Delegates. It reads as follows:

WHEREAS, Certain states restrict the quantity of medicinal liquor a physician may prescribe or administer to any one patient within a stated period, and

WHEREAS, Such statutory restrictions deprive the physician of his right to the free exercise of his judgment in the practice of his profession, and prevent him from employing medicinal liquor in such doses as are in his opinion therapeutically indicated and beneficial to his patients, and

WHEREAS, There are at present pending in the Congress of the United States two identical measures—S. 3090 and H. R. 10524—sponsored by the American Medical Association, which would remove statutory limitations governing the prescribing of medicinal liquor by physicians, therefore, be it

RESOLVED, That the House of Delegates of the Ohio State Medical Association in annual session May 3 and 4, 1932, at Dayton, Ohio, voice its approval of the principle that the dosage of a medicine should not be fixed by legislative fiat; endorse the above-named corrective measures, and urge their enactment, and be it further

RESOLVED, That a copy of this resolution be sent to each member of the Ohio Congressional Delegation, and to the members of the Senate and House Judiciary Committees before which these bills are pending.

On *motion* by Dr. Paryzek, *seconded* by Dr. DeWitt and *carried*, Resolution E as revised was accepted, approved and *adopted.*

RESOLUTION F

Introduced by C. W. Stone (Cuyahoga County.) In heartily endorsing and recommending for adoption the resolution on the medical care of veterans, your Committee is of the opinion that the arguments presented by the author of the resolution were so clearly and succinctly stated that they are deserving of a repetition in this report.

At the present time, under Sub-Section 10, Section 202 of the World War Veterans' Act of 1924 as amended, all ex-service men since 1897 may secure at government expense in governmental hospitals, medical, surgical and hospital care, even for those disabilities arising in civilian life and in no way connected with military service. The annual report of the U. S. Veterans' Bureau for 1931 indicates the admission to hospitals during that fiscal year of patients of the veterans' administration authorized under the World War Act, and that those admitted for temporary treatment or permanent custody for non-service connected disabilities totaled 75,427 as compared with 24,618 admitted for service connected disabilities; the admissions for general medical or surgical conditions, not tuberculous or neuropsychiatric, showing an even greater contrast of 30,303 for non-service connected disabilities and only 4,513 for service connected disabilities. The federal government now utilizes 322 institutions, 106 government-owned and the remainder on contract, in which veterans are admitted for treatment or custody. The federal government, at the present time, is supporting, in whole or part, approximately 883,355 World War veterans and their dependents. The number will inevitably increase as the veterans become older, and as the civilian disabilities increase in middle or later life. The present cost to the federal government of the veterans' benefits is approximately a billion dollars a year, with the prospect, according to the advocates of further executive benefits, that it possibly

may reach between two and three billion dollars annually.

The House of Delegates of the Ohio State Medical Association in 1925 adopted a Resolution, placing the medical profession of Ohio on record as believing that thorough and adequate medical, surgical and hospital service should be provided at government expense for veterans whose disabilities arise from military service, and even that such benefits might probably be available to those veterans with non-service connected disabilities who are unable to provide for themselves. That Resolution, however, definitely opposed, as governmentally and economically unsound, an extensive system which would provide medical, surgical and hospital service for non-service connected disabilities.

Recently a program has been suggested of utilizing available beds in civilian hospitals for local ex-service men with non-service connected disabilities and at government expense. *If* the federal government adheres to its policy of benefits for non-service connected disabilities, even to those veterans financially able to provide them for themselves, it is reasonable that local hospital facilities and local physicians should be utilized. However, such a plan is contrary to the policy previously adopted in 1925, and repeated from time to time in the annual reports of the Ohio State Medical Association Committee on Policy and adopted by the House of Delegates.

As a fundamental principle it may be said that those who were wounded or disabled in any manner in or from military service, are entitled to special benefits from the Nation in whose service such losses occurred; it is equally fundamental that diseases and injuries arising entirely in civilian life should be considered civil, local or individual problems, not as special programs of the federal government. The resolution reads as follows:

RESOLUTION

WHEREAS, The World War Veterans' Act of 1924, Sub-Section 10 of Section 202 provides, under certain procedure, for the hospitalization, medical and surgical service, and necessary traveling expenses to veterans of any war, military occupation or military expedition since 1897, not dishonorably discharged, *without regard to the nature or origin of their disabilities*, and

WHEREAS, Under the terms of that Act, a gradually increasing number of beneficiaries may be provided with hospital care, medical and surgical treatment at government expense, for diseases and injuries arising from civilian life and in no way connected with military service, and

WHEREAS, A plan has been proposed to halt the building of additional federal hospitals, except for neuropsychiatric and tuberculous cases, and to arrange for the medical treatment and hospitalization of veterans locally for non-service disabilities, and

WHEREAS, The first concern of the American people should be for adequate and thorough benefits to those veterans disabled through military service, and to the dependents of those who gave their lives in service to their country, and

WHEREAS, the present program of benefits may discriminate against the veterans and their dependents whose losses were incurred in military service, therefore be it

RESOLVED, That the House of Delegates of the Ohio State Medical Association at its annual meeting in Dayton, Ohio, May 3 and 4, 1932, re-affirms its established policy that adequate provision should be made for those whose physicial disabilities were incurred in or resulted from military service, and for the dependents of those who sacrificed their lives in the service of their country; but that we reiterate our opposition to a governmental or subsidized plan which would provide medical, surgical or hospital care to all ex-service men for non-service connected disabilities or injuries, and further be it

RESOLVED, That the President of the Ohio State Medical Association appoint a special committee to cooperate with the American Legion, Department of Ohio, in an endeavor to formulate the most beneficial program for the ex-service men and the American people.

On *motion* by Dr. Paryzek, seconded by Dr. Stone and *carried*, Resolution F was accepted, approved and *adopted.*

RESOLUTION G

Introduced by O. P. Klotz (Hancock County), is an expression of appreciation and approval of the efficient manner in which a number of our members contributed to the Scientific Exhibit which was inaugurated at the present session of the Ohio State Medical Association, and suggests that special mention be made of all scientific exhibitors, in the *Ohio State Medical Journal.*

Your Committee heartily approves of the commendation contained herein, and recommends that the resolution be adopted by the House of Delegates. It reads as follows:

WHEREAS, At the 86th annual meeting of the Ohio State Medical Association, there has been inaugurated a scientific exhibit, and

WHEREAS, A number of our members have devoted much of their time and energy toward this desirable feature, therefore, be it

RESOLVED, That the House of Delegates express their appreciation to the exhibitors and to the Committee on Scientific Exhibits, under the chairmanship of Dr. Walter M. Simpson, and be it further

RESOLVED, That the account of this annual meeting, published in the *Ohio State Medical Journal*, carry special mention of scientific exhibitors and the institutions they represent.

On *motion* by Dr. Paryzek, seconded by Dr. Harris and *carried*, Resolution G was accepted, approved and *adopted.*

On *motion* by Dr. Paryzek, seconded by Dr. Seibert and *carried*, the foregoing action by the House of Delegates on the various matters submitted by the Resolutions Committee was adopted as a whole.

Meeting Place for 1933

Dr. Sloan presented to the House of Delegates the formal invitation from the Academy of Medi-

cine of Cleveland for the 1933 Annual Meeting to be held in Cleveland. Dr. Davidson presented the invitation for the 1933 Annual Meeting to be held in Akron.

Dr. Houghtaling presented the invitation for the 1933 Annual Meeting to be held at Cedar Point.

In the course of discussion, it was brought out that the 1933 Annual Meeting of the American Medical Association might be held in Cleveland, and that the selection of the meeting place for next year would be made by the House of Delegates of that body at the New Orleans meeting, May 9 to 12; and that there would be many advantages in the State Association Annual Meeting being held jointly with the annual meeting of the A. M. A., in case the latter should be held in this state. In view of this situation and on *motion* by Dr. Jennings, seconded by Dr. Upham and *carried*, the entire queston of the selection of both the *time* and *place* for the 1933 Annual Meeting of the Ohio State Medical Association was delegated to the Council in accordance with the authority granted under Section 2 of Article VI of the Constituton.

Installation of New President

As his last official act before retiring as President and inaugurating Dr. Platter to the Presidency from the office of President-Elect, Dr. Houser expressed appreciation for the splendid and constructive spirit of support and cooperation by the House of Delegates, the officers, Council, county societies and membership generally during his term. Dr. Houser then called attention to the experience and qualifications of Dr. Platter and, in appropriate words, officially installed him as the President for the ensuing year by presenting to him the official gavel of the State Association.

On being installed, Dr. Platter expressed his hope that he would be able to serve the entire membership throughout his term, and solicited support, suggestions and cooperation. He expressed appreciation for the honor joined with the responsibilities which had come to him with his inauguration to the office of President.

Appointment and Confirmation of Standing Committees

Under the next order of business, as his first official act, President Platter, in conformity to Chapter IX, Section 1, of the By-Laws announced the appointment of one member each on the standing committees for a term of three years as follows:

Public Policy:

C. W. Stone, Cleveland.

Publication:

Gilbert Micklethwaite, Portsmouth.

Medical Defense:

F. P. Anzinger, Springfield.

Medical Education and Hospitals:

R. H. Birge, Cleveland.

Medical Economics:

E. O. Smith, Cincinnati.

Upon *motion* by Dr. Tatman, seconded by Dr. Emerick and *carried*, the House of Delegates concurred in the foregoing appointments.

Dr. Platter then announced the complete personnel of the standing committees under the constitution, including the hold-over members, the year in which the terms of members expire, and the chairman designation, as follows:

Committee on Public Policy:

John B. Alcorn, Chairman, (1933), Columbus; J. H. J. Upham, (1934), Columbus; C. W. Stone, (1935), Cleveland; Dr. H. M. Platter, (Ex-Officio), Columbus; C. L. Cummer, (Ex-Officio), Cleveland.

Committee on Publication:

Andrews Rogers, Chairman, (1934), Columbus; A. B. Denison, (1933), Cleveland; Gilbert Micklethwaite, (1935), Portsmouth.

Committee on Medical Defense:

J. E. Tuckerman, Chairman, (1934), Cleveland; W. H. Snyder, (1933), Toledo; F. P. Anzinger, (1935), Springfield.

Committee on Medical Education and Hospitals:

Ben R. McClellan, Chairman, (1934), Xenia; John F. Wright, (1933) Toledo; R. H. Birge, (1935), Cleveland.

Committee on Medical Economics:

J. Craig Bowman, Chairman, (1933), Upper Sandusky; A. B. Brower, (1934), Dayton; E. O. Smith, (1935), Cincinnati.

Words of Appreciation

Upon *motion* by Dr. Cummer, seconded by Dr. Shanley and *carried*, the House of Delegates, on behalf of the members of the State Association, officially expessed appreciation to the Montgomery County Medical Society, its committees and membership, to the local press, the hotels and others who contributed toward the success and pleasure of the 1932 Annual Meeting.

Further business being called for and there being none presented, the House of Delegates, upon *motion*, *adjourned* to the Eighty-Seventh Annual Meeting, the dates and place to be set by the Council, as previously authorized.

Attest: DON K. MARTIN,
Executive Secretary.

House of Delegates Roll Call

County	Delegate	First Session	Second Session
Adams	Ray Vaughen	present	present
Allen	Ezra Burnett	present	present
Ashland	L. G. Sheets	present	present
Ashtabula	R. B. Wynkoop	present	present
Athens	C. S. McDougall	present	present
Auglaize	Chas. P. McKee	present	present
Belmont	C. W. Kirkland	present	present
Brown	Geo. P. Tyler, Jr.	.....	.....
Butler	D. M. Blizzard	present	present
Champaign	E. W. Ludlow	present	present
Clark	D. W. Hogue	present	present
Clermont	Allan B. Rapp		present
Clinton	A. C. Roberts	present	present
Columbiana	J. M. King	.....	.....
Coshocton	Wilmer Hammond	.....	.....
Crawford	R. J. Caton	.....	.....
Cuyahoga	C. W. Stone	present	present
"	H. C. King	present	present
"	H. G. Sloan	present	present
"	C. D. Waltz	present	present
"	H. V. Paryzek	present	present
"	J. E. Tuckerman	present	present
"	D. M. Glover	present	present
"	C. G. LaRocco	present	present
"	L. J. Karnosh	present	present
Darke	C. I. Stephen	present	present
Defiance	Geo. DeMuth	present	.....
"	Paul B. Newcomb	.....	present
Delaware	A. R. Callander	present	.....
Erie	F. M. Houghtaling	present	present
Fairfield	R. H. Smith	present	present
Fayette	John F. Wilson	present	present
Franklin	John B. Alcorn	present	present
"	I. B. Harris	present	present
"	E. J. Emerick	present	present
"	John M. Thomas	present	present
"	J. H. J. Upham	present	present
Fulton	Harold Heffron	.....	.....
Gallia	S. L. Bossard	.....	.....
Geauga	C. F. Gilmore	.....	.....
Greene	M. I. Marsh	present	.....
Guernsey	B. A. Souders	present	present
Hamilton	J. V. Greenebaum	present	present
"	O. J. Seibert	present	present
"	Chas. E. Kiely	present	present
"	Louis Feid, Jr.	present	present
"	E. O. Smith	present	present
"	H. B. Freiberg	present	present
Hancock	J. V. Hartman	present	.....
Hardin	G. S. Wilcox	.....	.....
Harrison	A. C. Groves	.....	.....
Henry	Thomas Quinn	.....	.....
Highland	H. W. Chaney	present	present
Hocking	J. S. Cherrington	present	present
Holmes	.....	.....	.....
Huron	John A. Sipher	.....	.....
Jackson	J. J. McClung	present	present
Jefferson	Albert Weinstein	present	present
Knox	F. C. Anderson	present	present
Lake	R. E. Gardner	present	present
Lawrence	Cosper Burton	.....	.....
Licking	Emmet A. Moore	present	present
Lorain	S. V. Burley	present	present
Logan	C. K. Startzman	present	present
Lucas	Chas. Lukens	present	present
"	J. F. Wright	present	present
"	A. P. Hancuff	.....	present
Madison	R. S. Postle	.....	.....
Mahoning	W. H. Bennett	.....	.....
"	Joseph Rosenfeld	.....	.....
Marion	C. L. Baker	present	present
Medina	E. L. Crum	present	present
Meigs	Byron Bing	.....	.....
Mercer	R. E. Riley	present	present
Miami	Gainor Jennings	present	present
Monroe	.....	.....	.....
Montgomery	A. W. Carley	present	present
"	C. C. McLean	present	present
"	A. O. Peters	present	present
Morgan	Lee Humphrey	.....	.....
Morrow	F. M. Hartsook	present	present
Muskingum	M. A. Loebell	present	present
Noble	.....	.....	.....
Ottawa	C. J. Yeisley	.....	present
Paulding	T. P. Fast	.....	.....
Perry	J. G. McDougal	.....	.....
Pickaway	Howard Jones	.....	present
Pike	L. E. Wills	present	present
Portage	S. U. Sivon	.....	present
Preble	C. M. Treffinger	present	present
Putnam	C. O. Beardsley	present	present
Richland	J. S. Hattery	.....	.....
Ross	O. P. Tatman	.....	present
Sandusky	J. L. Curtin	.....	.....
Scioto	Gilbert Micklethwaite	present	present
Seneca	R. C. Chamberlain	present	present
Shelby	Kenneth Hauver	present	
Stark	J. P. DeWitt	present	present
"	Chas. A. LaMont	.....	.....
Summit	F. C. Potter	present	present
"	W. A. Hoyt	present	present
"	R. E. Amos	present	present
Trumbull	Frank La Camera	.....	.....
Tuscarawas	J. W. Calhoon	.....	.....
Union	J. D. Boylan	present	present
Van Wert	A. T. Rank	present	present
Vinton	A. A. Boal	.....	.....
Warren	N. A. Hamilton	present	present
Washington	A. Howard Smith	.....	.....
Wayne	R. C. Paul	present	present
Williams	J. A. Weitz	.....	.....
Wood	E. D. Foltz	present	present
Wyandot	J. Craig Bowman	present	present
	OFFICERS		
President	D. C. Houser	present	present
President-elect	H. M. Platter	present	present
Ex-President	C. W. Waggoner	present	present
Treasurer	James A. Beer	present	present
	COUNCILORS		
First District	John A. Caldwell	present	present
Second District	E. M. Huston	present	present
Third District	O. P. Klotz	present	present
Fourth District	B. J. Hein	present	present
Fifth District	C. L. Cummer	present	present
Sixth District	H. S. Davidson	present	present
Seventh District	E. B. Shanley	present	present
Eighth District	E. R. Brush	present	present
Ninth District	I. P. Seiler	present	present
Tenth District	S. J. Goodman	present	present
	Total	90	92

The following have been granted medical and surgical licenses through reciprocity by the State Medical Board:

Abel A. Applebaum, Toledo, University of Michigan; Daniel C. Barrett, Cincinnati, Indiana University; Abraham L. Ceasar, Cleveland, Cornell University; Lonnie A. Curry, Akron, Meharry Medical College; Bernard J. Goldfarb, Cleveland, Fordham University; Allan E. Lee, Cleveland, University of Michigan; Edwin L. Libbert, Cincinnati, Indiana University; Martin H. Lovell, Portsmouth, Meharry Medical College; Howard A. Martin, Toledo, University of Michigan; Francis Matulaitis, Cleveland, Baltimore Medical College; Henry A. Monat, Cincinnati, University of Arkansas; John A. Mooney, Kenton, University of Michigan; Frederick P. Osgood, Toledo, University of Michigan; Malcolm M. Riddell, Fremont, University of Louisville; Albert T. Steegmann, Cleveland, University of Kansas; Walter J. Urben, Massillon, University of Wisconsin; Judson D. Wilson, Columbus, Indiana University; John J. Harrington, Cleveland, University of Pennsylvania; James P. McAfee, Portsmouth, University of Louisville; Archibald R. Stone, Columbus, Washington University.

Montreal, Canada, was chosen as the 1933 convention city for the Amercican College of Surgeons, at the recent annual meeting of the college, held at San Francisco.

Minutes of Council Meetings During the Eighty-Sixth Annual Meeting of The Ohio State Medical Association

Minutes

The Council of the Ohio State Medical Association convened at a dinner meeting in the Van Cleve Hotel, Dayton, Ohio, on Monday evening, May 2, at 6:30 P. M., on the evening preceding the opening of the 86th annual meeting of the State Association in Dayton.

The officers and Councilors present were: President, Dr. Houser; President-elect, Dr. Platter; Ex-President, Dr. Waggoner; Treasurer, Dr. Beer; Councilors, Drs. Caldwell, Huston, Klotz, Hein, Cummer, Davidson, Shanley, Brush, Seiler, Goodman. Others present on invitation were: Dr. Alcorn, chairman of the Policy Committee; Dr. Rogers, chairman of the Publication Committee; Dr. Tuckerman, chairman of the Medical Defense Committee; Dr. Stone, member of the Policy Committee; Dr. Bigelow, former president; Dr. Kislig, president of the Montgomery County Medical Society; Dr. Carley, general chairman on Local Arrangements; Executive Secretary Martin and Assistant Executive Secretary Nelson.

Following the dinner the Council convened in a business session at 7:30 P. M. Dr. Houser, in opening the meeting, expressed appreciation to the Council, officers and committees for their cooperation and assistance during his term of office, and indicated credit due them for the accomplishments of the State Association. He emphasized the efforts and the sacrifices made by the committees and officers in the performance of their duties.

The minutes of the Council meeting held on March 6, 1932, in the headuarters office of the State Association in Columbus (published on pages 293-296, inclusive, of the April, 1932, issue of *The Journal)* were read, and on *motion* by Dr. Hein, seconded by Dr. Shanley and *carried*, were *approved.*

Dr. Huston, chairman of the Council Committee on Arrangements for the annual meeting, summarized briefly the plans made by the local committees for the entertainment of the annual meeting, and announced that preparation had been made for all details. Dr. Carley and Dr. Kislig also reported briefly.

Constitutional Questions

Dr. Cummer, chairman of the Council Committee on Constitutional Conformity, reported on developments by component societies toward completion of their constitutions since the last Council meeting. He submitted, with recommendation for approval, the completed Constitution and By-Laws of the

Clark County Medical Society

with amendments as recently adopted upon the recommendation of the Council Committee on Constitutional Conformity.

On *motion* by Dr. Huston, seconded by Dr. Klotz and *carried*, the Constitution and By-Laws of the Clark County Medical Society were *approved.*

Dr. Cummer reported that the required amendments, as recommended by his Committee to the Mahoning County Medical Society, were being considered by a committee of that society and undoubtedly would be adopted in the near future. This report also showed that the constitutions and by-laws of all other societies had now been completed in conformity with provisions and requirements of the Constitution and By-Laws of the State Association, except those of Monroe and Noble counties.

The Committee discussed the proposed and pending amendments to the Constitution and By-Laws of the State Association to be considered officially by the House of Delegates at its meeting on Tuesday morning, May 3, as published in the March issue of *The Journal*, pages 199-201, inclusive. Dr. Cummer requested expressions of opinions, from members of Council, on the amendments which he had proposed (series of amendments No. 1), to provide for four councilors-at-large. He stated that perhaps the time is not appropriate for constitutional changes in this regard, and until the House of Delegates and the membership should have further opportunity to consider a number of alternative suggestions, including the possibility of increasing the number of councilors by an increase in the number of councilor districts, and other suggestions for a councilor set-up with additional members.

Upon *motion* by Dr. Huston, seconded by Dr. Cummer and *carried*, it was expressed as the sense of the Council that proposed amendments No. 1 should be withdrawn at this time, and the Council recommended to the author of the amendments that he withhold his support from them at this annual meeting.

Publication Problems

Pursuant to the action of Council at its last meeting in referring to the Publication Committee, a request for an official report on correspondence with Dr. Henry Wald Bettmann of Cincinnati, Dr. Rogers, chairman of the Publication Committee, was introduced, and submitted the following written report:

To the Council of the Ohio State
Medical Association:

At the request of the Council, each member of the Publication Committee has considered the paper on "Hyperchlorhydria in Older People", by Dr. Henry Wald Bettmann and Dr. Louis Som-

mer of Cincinnati, presented before the Medical Section at the 1931 annual meeting, together with the correspondence relating to that paper, and the action of Council, itself, at its meeting on March 6, 1932.

Undoubtedly Dr. Bettmann is correct in his assertion that the paper is based on interesting clinical observations. The Committee, however, is unable to determine from the paper itself just what those clinical observations were, and in spite of the fact that there was undoubtedly much material of interest on which the paper is based, such material is not clearly presented. Moreover, this Committee does not consider the standing or ability of authors, but only the papers submitted by them for publication, from the standpoint of clarity, correctness and practical value, bearing in mind at all times that a large proportion of the readers of our *Journal* are in general practice rather than in various specialties.

Apparently the Council desires the reasons of the Publication Committee in rejecting Dr. Bettmann's and Dr. Sommer's paper, and the Committee is unanimous in the following reasons:

1. The paper is loosely constructed, especially in the presentation of its purpose.
2. The "set-up" is poor, lacking in consecutive construction.
3. Many "impressions" of the authors are presented without a presentation of the facts to substantiate them.
4. The directions for diagnosis and treatment are not specific.

The Publication Committee respectfully calls the attention of the Council to the fact that its judgment requires it occasionally to reject papers submitted by members of the State Association. This is an unpleasant and thankless task. We may be wrong in our judgment, but such judgment as we have is honestly and impartially applied.

Moreover, we respectfully call the Council's attention to the Constitutional duties of this Committee, which are, indeed, quite as specific as the separate Constitutional duties of the Council itself. We are quite aware of the fact that the Council has authority to instruct the Committee on matters of policy and procedure as illustrated on several occasions when this Committee requested the Council for guidance on the acceptance or rejection of advertising and similar matters. The Council may, of course, consider on appeal, or otherwise, any charges against this Committee for abuse of discretion, for any alleged acts exceeding its authority or for non-performance of duty, but we do not feel that the Council, under Constitutional provision, should supervise or reverse our scientific and editorial judgment.

Fraternally,
PUBLICATION COMMITTEE,
By ANDREWS ROGERS, M.D., *Chairman.*

Upon *motion* by Dr. Seiler, seconded by Dr. Waggoner and *carried*, the above report was accepted and approved, following which there was a general discussion on respective duties and the necessity of understanding and cooperation between the Council and the Publication Committee.

Question of Time and Place of Annual Meeting

Dr. Stone was requested to inform the Council on the probability of the 1933 annual meeting of the American Medical Association being held in Cleveland, and to express his opinion on the suggestion that the annual meeting of the State Association next year might be held at the same time and place. Dr. Stone informed the Council of the tentative plans already made by the Academy of Medicine of Cleveland to entertain the 1933 annual meeting of the American Medical Association in case the House of Delegates of that organization should select Cleveland for the next meeting, at the meeting of that body in New Orleans, May 9 to 12, 1932. Various Councilors discussed the possible advantages to the membership in attending the one meeting jointly in Cleveland in case that city should be selected. The Council also discussed several pending invitations from other cities for the 1933 annual meeting af the State Association, and it was the consensus of opinion that if the A. M. A. 1933 meeting comes to Cleveland, it would be desirable for the State Association to meet in the same city at the same time, avoiding, of course, any conflict in the sessions, and to utilize the scientific program of the A. M. A. as the scientific program for the members of the State Association. Most of those who discussed the matter felt that the recommendation should be made to the House of Delegates of the State Association that the question of both the time and place of the 1933 annual meeting be left with the Council, pending action by the House of Delegates of the A. M. A.

In this connection, the Council decided to withhold introduction in the House of Delegates of a resolution previously suggested to change the time of the meeting of the State Association in 1933 from the Spring, probably May as has been customary, to sometime in the Fall, probably October; and that any decision on such a change had best be deferred at this annual meeting.

Question of a Woman's Auxiliary

President Houser called attention to the hearing held during the last meeting of the Council on the question of a Woman's Auxiliary, and the action of the Council at that time in creating a special committee to submit to the Council at this time, a report and recommendations on this question.

The following report was submitted:

At the last meeting of Council on March 6, 1932, we had the pleasure of a hearing on the question of a Woman's Auxiliary to the Ohio State Medical Association.

Those who spoke on that occasion were Mrs. Arthur B. McGlothlan, St. Joseph, Mo., President of the Woman's Auxiliary of the American Medical Association; Mrs. James Edwin Purdy, Canton, Ohio, President of the Woman's Auxiliary of the Stark County Medical Society; and Mrs. A. A. Ahn, Columbus, Ohio, state organizer for the national Woman's Auxiliary.

The speakers presented the purposes, programs and activities of a Woman's Auxiliary from the standpoint of national, state and county organization. Action on the question was deferred to this meeting. (Council minutes, page 296, April, 1931, *Journal*).

We sincerely appreciate the motive of those women members of our families, as well as others who desire to support the aims and objects of medical organization. We naturally expect, and have never been disappointed in expecting, the support and cooperation of our wives and daughters, in whatever way they can assist, in the promotion of scientific medicine and the protection of public health. We could recount innumerable examples where wives and daughters of physicians, through their membership in various women's clubs, civic groups and even in public positions, have rendered splendid public service. This is as it should be.

It has been suggested that through a Woman's Auxiliary, authoritative health literature and constructive public health programs, in various women's civic organizations, could be procured and promoted.

Abundant authoritative literature on this subject is already available, and naturally we assume that our wives and daughters, in their respective fields of interest and activity, will seek authoritative information on these public subjects on which the medical profession itself is best informed; whether or not an Auxiliary exists for its collection and dissemination. In all proper fields of public activity we naturally expect our wives and daughters to take just as much interest as individuals, or as members and officers of other women's groups, as if they were stimulated by Auxiliary programs and policies.

The Council has not intended nor does it now intend to imply that it is lacking in appreciation of the active and outstanding public and social service rendered by physicians' families. However, we feel there has been a tendency toward over-organization in the past, and that the present unsettled situation should indicate a trend toward simplification.

We are not informed of the degree or extent of interest among the families of physicians on the questions of a Woman's Auxiliary. Thus far, there has been manifest a desire for a Woman's Auxiliary only from two or three communities in this state. Moreover, this question has been repeatedly before the Council of the State Medical Association since 1924, and thus far the Council has not been convinced of any widespread demand, nor of the necessity or desirability for an Auxiliary.

In fact, the established policy and precedent of our State Association precludes us from giving official approval to any organization not made up of our own members, and for numerous reasons it seems best to adhere to this precedent.

The Council, therefore, considers itself unable to issue an official endorsement, or to assume responsibility for the creation of a State Woman's Auxiliary.

This does not prevent the creation of local Auxiliaries in those communities where the county medical societies favor such organizations, and where they assume the necessary responsibility for and guidance over their activities.

Upon *motion* by Dr. Caldwell, seconded by Dr. Seiler and *carried*, the foregoing report was approved and adopted by a rising vote of ten to two.

Questions Relating to Veterans

Dr. Alcorn, chairman, and members of the Policy Committee reported in detail to the Council on a conference of the Policy Committee with the Institutions Committee including members of the Rehabilitation Committee of the Ohio Department of the American Legion, and representatives of the Ohio Hospital Association, held in Columbus on Sunday, April 24, relative to the many problems, governmental, sociological and medical, in the present program of the federal government, and proposed legislation in relation to medical and hospital care to veterans for non-service connected disabilities.

Dr. Stone submitted to the Council a resolution, accompanied by a preamble or explanatory statement, which had been prepared by the Policy Committee pertaining to these questions following the conference with the officials of the American Legion. Following a general discussion, the Council expressed its opinion that the resolution, with the explanatory statement, should be submitted to the House of Delegates for action.

Miscellaneous

There was submitted, for the information of the Council, a communication from Mr. B. W. Stewart of Youngstown, chairman of the Legislative Committee of the Ohio Hospital Association, relative to the losses by hospitals in services rendered to persons, especially transients, in automobile accidents. He indicated the intention of the hospitals to again introduce in the Ohio Legislature a bill to compensate hospitals for services rendered indigents injured in automobile accidents, perhaps from the Automobile License Fund under the Division of Motor Vehicles in the Secretary of State's Department. He requested expressions of opinion from the Council in regard to cooperation on this issue, and the sentiment in regard to the possibility of including in the bill provision for the compensation of physicians rendering services in such cases.

Upon *motion* by Dr. Platter, seconded by Dr. Cummer and *carried*, this problem was submitted to the Policy Committee with a request for a report and recommendation on which a policy might be based.

Dr. Davidson submitted to the Council a communication to him from Dr. Paul C. Langan of Akron, accompanied by other documents pertaining to the procedure of the Industrial Commission in payment for *X*-rays in workmen's compensation cases. In this material, discrepancies were pointed out in regard to compensation as between physicians individually rendering professional services in *X*-ray work and hospitals where such services in some cases are included in the per diem allowed the hospital, and in which latter cases the physicians performing the work or interpreting the *X*-ray pictures have not been compensated.

Upon *motion* by Dr. Hein, seconded by Dr. Klotz and *carried*, these communications and this question were submitted to the Medical Economics

Committee with a request for investigation, consideration and report.

Dr. Tuckerman, chairman of the Medical Defense Committee, reported to and discussed with the Council technical legal questions pertaining to medical defense, including legal points and court decisions in the corporate practice of law. He distinguished between the unauthorized practice of law by corporations, agencies and associations, and the medical plan of the State Association, which is not in competition with attorneys in practice; and in which the State Association does not profit from the legal services which it employs.

Membership statistics were submitted for the information of the Council, tabulated by Councilor Districts, showing a total membership in the State Association to date for 1932 of 5,058, as compared with 5,191 on the same date last year, and as compared with the total of 5,489 at the end of 1931. Councilors pledged themselves to an effort in cooperation with the officers of the county societies in their districts to secure payment of dues by delinquent members, and an effort to secure as members eligible physicians not now affiliated.

Upon *motion* by Dr. Goodman, seconded and *carried* unanimously, the Council expressed to Dr. Houser appreciation for his courteous and kindly treatment during his term as president, and for the splendid service rendered by him in that position.

The Council adjourned to meet with the House of Delegates at the Dayton-Biltmore Hotel at 9:30 on the following morning, May 3.

With the House of Delegates

The Council of the Ohio State Medical Association met with, and as a part of, the House of Delegates at the Dayton-Biltmore Hotel, Dayton, on Tuesday, May 3, at 9:30 A. M., and also with the second and last session of the House of Delegates during the annual meeting at 3:30 P. M. on Wednesday, May 4, and participated officially in both sessions. Minutes of the Council meetings with the House of Delegates are included as part of the proceedings of the latter in this issue of *The Journal.*

Final Council Session

The final session of the Council during the 86th annual meeting, was held at 4:45 P. M., following the final adjournment of the House of Delegates. By acclamation, Dr. S. J. Goodman was again selected as Secretary of the Council for the eleventh consecutive term.

The Council adjourned to meet at a suitable time upon call of the President, probably in July.

S. J. GOODMAN, M.D.,
Secretary of Council.

Well-Attended and Successful Annual Meeting in Dayton Marks Another Milestone in Organization Progress

With a registration which surpassed expectations, the Eighty-Sixth Annual meeting of the Ohio State Medical Association, held May 3 and 4, at Dayton, brought to a close another year of activity and outstanding accomplishments on the part of organized medicine in Ohio.

The registration at the Dayton meeting, recorded despite unsettled conditions which have directly affected the medical profession, demonstrated again to a marked degree the loyalty of the medical profession of Ohio to the ideals and principles of medical organization; their enthusiasm for those opportunities to participate in the accomplishments of scientific medicine; and their desire to take an active interest in discussions of social and economic questions affecting public health, scientific medicine, and medical practice.

The 1932 annual meeting was especially significant because it re-demonstrated that regardless of adversities which affect the practice of medicine and the physician individually, the medical profession is ever anxious and eager to promote the cause of scientific medicine and to better equip itself to overcome disease, and to protect the health of the public.

* * *

The prevailing sentiment regarding the programs presented at the sessions of the six scientific sections and the general scientific session was that collectively the scientific essays and discussions were valuable and interesting, appealing to both general practitioners and specialists.

Every session of the scientific sections was largely attended, attesting to the widespread interest which had been aroused by the subjects and scope of the various papers scheduled.

Because of the painstaking preparation made by the various essayists and discussants, those who attended the scientific gathering were amply repaid for the time devoted to the scientific phase of the meeting. In a few instances the papers, while excellent, exceeded the time assigned to them and thus deprived others of their allotted time.

The general scientific session on Wednesday afternoon when the program was presented by representatives of Ohio's three Class A medical schools—Ohio State University, University of Cin-

cinnati, and Western Reserve University—met with the general approval of approximately 800 who attended this feature of the meeting.

* * *

Under the able chairmanship of the President, Dr. D. C. Houser, Urbana, the House of Delegates transacted with efficiency and dispatch an unusually large number of important business matters at its two sessions.

Each session of the House of Delegates was well attended and most of the delegates took an active interest in the proceedings which indicated that those selected by the various county medical societies and academies of medicine to represent them in transacting the business of the State Association were not only well informed concerning the questions confronting medical organization, but had devoted thought and study in advance to the important matters under consideration.

The first session of the House of Delegates on Tuesday morning was officially opened by Dr. F. K. Kislig, president of the Montgomery County Medical Society, who welcomed the medical convention to Dayton and extended to the physicians of Ohio the hospitality of Dayton and the medical profession of that city. Dr. Kislig then presented the President, Dr. Houser, who immediately called the House of Delegates to order.

The business transacted at the opening session of the House of Delegates consisted of the presentation of the annual reports of the officers and the standing and special committees, which reports had been published in the May, 1932, issue of *The Journal;* appointment of the various reference committees by the President; election of a nominating committee; introduction of resolutions, and action on pending amendments to the Constitution and By-Laws of the State Association, published in the March, 1932, issue of *The Journal.*

The second and final session of the House of Delegates was held on Wednesday afternoon at which Dr. H. M. Platter, Columbus, was installed as president and Dr. C. L. Cummer, Cleveland, since 1927 councilor of the Fifth District and for many years active in medical organization, was elected president-elect for 1932-33.

Four members of the Council whose terms expired were re-elected, namely: Dr. John A. Caldwell, Cincinnati, First District; Dr. O. P. Klotz, Findlay, Third District; Dr. E. B. Shanley, New Philadelphia, Seventh District, and Dr. I. P. Seiler, Piketon, Ninth District.

Dr. H. V. Paryzek, Cleveland, was elected Councilor of the Fifth District, succeeding Dr. Cummer who had been elected president-elect.

Dr. Wells Teachnor, Sr., Columbus; Dr. Ben R. McClellan, Xenia; Dr. E. R. Brush, Zanesville, and Dr. C. W. Stone, Cleveland, were re-elected delegates to the American Medical Association for a term of two years, with the following alternates, respectively: Dr. D. H. Morgan, Akron; Dr. A. C. Messenger, Xenia; Dr. A. Howard Smith, Marietta, and Dr. C. L. Cummer, Cleveland.

Following action by the House of Delegates on the reports of the reference committees, invitations to hold the 1933 meeting of the State Association in Cleveland, Akron and Cedar Point were presented. Dr. H. G. Sloan, Cleveland, pointed out to the House of Delegates that the Academy of Medicine of Cleveland had invited the American Medical Association to meet in Cleveland next year. He said the Academy believed if the invitation to the A.M.A. should be accepted that it would be opportune to have the State Association hold its annual meeting in Cleveland at the same time. Following a general discussion, the House of Delegates voted, in view of the uncertainty as to whether Cleveland would be selected as the 1933 meeting place for the American Medical Association, to refer the question of time and place for the 1933 meeting of the State Association to the Council, with power to act.

Following the installation of the new President, Dr. Platter, and the other officers, Dr. Houser briefly expressed appreciation for the loyalty and cooperation of the membership during his tenure of office and tendered the official gavel to Dr. Platter, who took charge of the meeting and announced appointments to the standing committees of the State Association, which appointments were confirmed by the House of Delegates. The following appointments were made: Dr. C. W. Stone, Cleveland, to succeed himself as a member of the Committee on Public Policy; Dr. Gilbert Mickelthwaite, Portsmouth, to succeed himself as a member of the Publication Committee; Dr. F. P. Anzinger, Springfield, to succeed himself as a member of the Committee on Medical Defense; Dr. R. H. Birge, Cleveland, to succeed himself as a member of the Committee on Medical Education and Hospitals, and Dr. E. O. Smith, Cincinnati, to succeed himself as a member of the Committee on Medical Economics.

The official record of the proceedings of the House of Delegates will be found elsewhere in this issue of *The Journal.*

* * *

The annual address of the President, Dr. Houser, and the President-elect, Dr. Platter, were presented on Tuesday evening following a banquet in the ballroom of the Dayton-Biltmore Hotel staged by the Montgomery County Medical Society. The complete texts of the annual addresses are published elsewhere in this issue of *The Journal.*

The banquet, all the arrangements for which were made and carried out by the Dayton Entertainment Committee, headed by Dr. C. H. Tate, and composed of Drs. B. W. Beatty, R. A. Lewis, Sterling H. Ashmun and Mack Shafer, was well attended, approximately 650 being present. A number of members who had not purchased tickets to the banquet missed the addresses.

During the dinner, a program of instrumental music and ballet dancing was presented.

Dr. C. W. Waggoner, Toledo, former president of the State Association, was called upon by Dr. Tate, the toastmaster, to make the presentation to Dr. Houser, the retiring president, of an official Past-President's gavel.

One of the features of the banquet program was an address by John B. Kennedy, an associate editor of Collier's and master of ceremonies on the "Collier's Hour".

Mr. Kennedy, in his well-known radio style, spoke on the subject, "Civics For Civilized Men", in which he declared that despite her critics, America today has builded a civilization which is the most satisfactory the world has ever known. Mr. Kennedy refuted the statement that America is turning cynical and discarding spiritual things for those which are entirely materialistic. To illustrate his point that America has a spirit and through its unique civilization has done more for humanity than any previous civilization, Mr. Kennedy recited numerous incidents in connection with interviews he has had with well-known and internationally-famous personages, ranging from Charles W. Eliot to Al Capone, each incident revealing a spiritual element beneath what might be hastily considered as wholly materialistic.

At the conclusion of the program, an informal reception for the President and President-elect was held.

* * *

Due to the constant and efficient work of the various Dayton committees in handling the many details during the meeting, every accommodation to make the meeting a success was provided.

Under the industrious general direction of Dr. E. M. Huston, Dayton, chairman of the Council Committee on Arrangements; Dr. F. K. Kislig, president of the Montgomery County Medical Society, and Dr. A. W. Carley, general chairman of the local committees, the Dayton committee carried out innumerable details.

The Reception Committee, headed by Dr. H. H. Herman, included Dr. L. G. Bowers, Dr. Robert C. Austin, Dr. H. V. Dutrow, Dr. A. F. Kuhl, Dr. M. R. Haley, Dr. Clarke C. Sullivan, Dr. Homer D. Cassel and Dr. Benedict Olch, and all were active in their functions.

An excellent piece of work was done by the Committee on Stereopticon under the chairmanship of Dr. Harry Burnett and composed of Dr. C. D. Fife, Dr. F. L. Shively, Dr. J. D. Foutz, Dr. W. B. Taggart, Dr. F. C. Payne and Dr. James Sagebiel. Lanterns for the various scientific meetings were set up in advance of the opening of each session. Each lantern was tested and manned by trained operators. Due to the efficiency of Dr. Burnett and his committee, few, if any, delays were encountered at the section meetings.

Dr. C. R. Weis and his Committee on Halls and Meeting Places performed in a faithful manner and handled the set-ups for the different meeting places. In addition to Dr. Weis, the committee was composed of Dr. N. C. Hochwalt, Dr. Ben Suffron, Dr. Leo Schram, Dr. W. S. Powell, Dr. H. L. Strohmeyer, Dr. E. J. Duffey, Dr. R. C. McNelly, Dr. Alex C. Rab, Dr. T. E. Newell, Dr. E. A. Sherk, Dr. T. K. Kirk, Dr. Fred P. Bucher, and Dr. Orville Burke.

Arrangements for the attractive commercial exhibits were carried out by Dr. D. B. Conklin, chairman of the Committee on Exhibits, and his committee, consisting of Dr. H. F. Koppe, Dr. R. K. Finley, Dr. Henry Snow, Dr. C. D. Smith, and Dr. J. K. Hoerner. The lay-outs and accommodations provided won the approval of practically all the exhibitors and the general appearance of the whole exhibit occasioned much favorable comment from many of those who attended.

* * *

An interesting and varied program of medical and surgical clinics was presented on Monday, the day preceding the opening of the Annual Meeting by members of the Montgomery County Medical Society. Many of the visiting physicians who arrived in Dayton in advance of the meeting attended the clinics held at Miami Valley Hospital, Dayton State Hospital, St. Elizabeth Hospital and the United States Veterans' Hospital. Those who were privileged to attend this added attraction were loud in their praise of the well-balanced and valuable demonstrations.

Among Dayton physicians who took part in the clinics and demonstrations were: Drs. W. B. Bryant, Earl Smith, A. B. Brower, Warren Breidenbach, C. G. Giffen, L. G. Kauffman, W. A. Ricketts, G. C. Gilfillen, J. C. Walker, R. D. Hostetter, H. M. James, C. Sidney Smith, H. H. Wagner, R. L. Johnston, Curtis Ginn, T. K. Kirk, Homer Cassel, J. K. Hoerner, S. H. Ashmun, J. A. Judy, W. R. Hochwalt, H. S. Gogstetter, M. D. Place, M. A. McKenzie, J. W. Millette, S. B. Woodward, W. F. Coakley, L. G. Bowers, E. R. Arn, H. R. Huston, E. M. Clark, C. A. Coleman, E. C. Fischbein, J. W. Brewer, F. C. Payne, W. H. Bradford, C. J. Kenny, A. J. Brainard, Vernon Roberts, and Dr. E. L. Hopper and his staff at the Dayton State Hospital.

* * *

One of the popular, as well as one of the most instructive features of the meeting was the Scientific Exhibit. The large and constant attendance at the Scientific Exhibit indicated that this feature met with the approval of the membership generally and was regarded as a valuable addition to the scientific program.

Recognition of the uniformly excellent character of the scientific exhibits and the value of such collective demonstrations was taken by the House of Delegates which, at its final session, adopted a resolution of appreciation and commendation to those who contributed to the exhibit and to Dr. Walter M. Simpson, director of the Diagnostic Laboratories, Miami Valley Hospital,

Dayton, who arranged for and supervised the exhibit, and Dr. Foy C. Payne, Dayton, who assisted Dr. Simpson.

A brief description of the different lay-outs composing the Scientific Exhibit follows:

Studies of the Physiology of the Male Sex Hormone with Especial Reference to Prostatic Hypertrophy. William E. Lower, N. F. Hicken, and W. K. Cuyler, Cleveland Clinic Foundation Research Department, Cleveland.—Experimental researches of the physiology of the prostrate gland, undertaken with the hope that it might lead to the discovery of factors in the causation of hypertrophy and possible means for its prevention.

Structural and physiologic changes in the prostate gland were produced by the following means: 1. Section of the nerves and vessels of the prostate gland; 2. Alteration of normal testicular function by castration, cryptorchidism, ischemia and X-ray and radium irradiations; 3. Injection of anterior lobe pituitary extract; 4. Parabiotic union of two animals; 5. The injection of silver nitrate, alcohol, sodium hydroxide, argarol, phenol, iodoform and Lugol's solution directly into the prostate gland.

Investigation of the source and distribution of the male sex hormone and its relation to the prostate, made in 200 normal individuals and patients of all ages, indicated intimate functional interrelation of hypophysis, testes and prostate gland.

These investigations indicate that prostatic hypertrophy may, in part, be due to a disturbance of the endocrine system. Any functional disorder of the hypophysis or the testes resulting in a hypersecretion of male sex hormone may cause enlargement of the prostate.

The Friedman Test for Pregnancy. Ernest Scott, H. L. Reinhart, Tom F. Lewis, Department of Pathology, Ohio State University, Columbus.—Animal demonstrations and the presentation of gross pathological specimens and photobmicrographs illustrating the various phases of the reactions of the ovaries, uteri, and pituitary gland of virgin doe rabbits to the intravenous introduction of the anterior pituitary hormone-containing urine. Schematic charts illustrated the influence of the pregnancy cycle upon the uterus, ovaries and pars anterior of the pituitary body in rabbits and women.

Roentgenological Diagnosis in Cardiac Disease. David Steel, Department of Roentgenology, Western Reserve University, Cleveland.—Reduced teleoroentgenograms of the various common cardiac lesions taken in the postero-anterior and oblique views to show the various forms of silhouettes assumed by the heart in these lesions. Autopsy specimen in colors. The usual lesions were the mitral, aortic and tricuspid valvular defects. The unusual cases were those of enlargement of the left auricle, which enlargement appears in the roentgenograms as a bulge to the right and not to the left. These lesions are demonstrable only by the roentgenogram method. Cases of early luetic aortitis were demonstrated.

Rickets and Rachitic Spasmophilia: Observations on the Etiology, Prevention and Cure. H. J. Gerstenberger, J. I. Harman, J. D. Nourse, G. R. Russell, A. J. Horesh, D. N. Smith, and D. G. Shields, Babies and Childrens Hospital, Cleveland.—Certain phases of infantile rickets and spasmophilia, based upon studies during the past ten years.

Group 1 demonstrated the efficacy and dosage of ultra-violet rays for the successful cure of infantile rickets.

Group 2 demonstrated the efficacy and dosage of cod liver oil in the cure and prevention of rickets.

Group 3 illustrated the failures and successes in making human milk adequately antirachitic by the daily feeding of the antirachitic factor to wet nurses.

Group 4 illustrated the etiologic rôle in rachitic spasmophilia of the inadequate application of the antirachitic factor in the cure and prevention of rickets, usually as the result of the interruption of otherwise adequate antirachitic therapy.

X-ray Studies of the Neck, Bronchi and Esophagus. Samuel Iglauer and Samuel Brown. Roentgenograms from the Cincinnati General and Jewish Hospitals, and Department of Otolaryngology, University of Cincinnati, Cincinnati.—Roentgenograms illustrating foreign bodies in the esophagus, larynx and tracheobronchial tree, including safety pin in the esophagus, ordinary pin in the larynx, collar button in the esophagus and a screw in the left main bronchus. Retropharyngeal abscesses were illustrated. Various lesions of the esophagus, including cardiospasm, carcinoma, diverticula and strictures due to lye, and the intubation method of injecting the rachea and bronchi with lipiodol for the demonstration of bronchiectasis and lung abscess were shown.

Neurosurgical Technique. William James Gardner, Cleveland Clinic, Cleveland.—One hundred photographs of neurosurgical technique depicting an operating chair devised for performing cranial operations with the patient in a sitting position. The photographs were arranged in series, one depicting various stages of the operation for cerebellar tumor; another depicting the various steps for the operation upon a parietal lobe tumor. The surgical approach to the optic chiasm was illustrated as well as the surgical technique for the removal of the right cerebral hemisphere in cases of infiltrating gliomas.

X-ray Studies of Some Orthopedic Lesions. Joseph A. Freiberg and Samuel Brown, Department of Orthopedic Surgery, University of Cincinnati, Cincinnati.—X-ray studies of numerous common and unusual osseous lesions, with postoperative results of several cases in which complicated surgical procedures were resorted to in order to obtain satisfactory functional end-results. Included were hip operations for slipped femoral epiphysis, ankylosis following arthritis, fractured neck of the femur with non-union, and resection of the radius with bone transplantation. A series of skull films demonstrated the characteristic changes in generalized systemic disturbances of the osseous system, showing lateral views of skulls in Paget's disease, hydrocephalus, marble-bone disease, leontiasis ossia, acromegaly, and osteogenic sarcoma of the frontal bone. Another

group included the more common benign and malignant bone tumors.

* * *

Special entertainment was provided by the wives of Dayton physicians for the wives of visiting physicians and other women guests. On Tuesday a luncheon was given by the wives of Dayton physicians at the Dayton Country Club for 160 persons, about 75 of whom were women from other cities. A talk was made at the luncheon by Mrs. A. A. Ahn, Columbus, after which bridge was enjoyed and many of the visitors were shown through some of the beautiful private gardens of Dayton. The following Dayton women had charge of the luncheon: Registry, Mrs. H. V. Dutrow, chairman; Mrs. L. G. Bowers, Mrs. E. C. Fischbein, Mrs. H. Snow, Mrs. Curtis Ginn; transportation committee, Mrs. E. M. Huston, chairman, Mrs. H. M. James, Mrs. A. F. Kuhl, Mrs. H. W. Burnett, Dr. Eleanora Everhard; luncheon committee, Mrs. C. H. Tate, chairman, Mrs. F. K. Kislig, Mrs. W. H. Delscamp, Mrs. A. W. Carley and Mrs. Clarke Sullivan. Miss Mildred E. Jeffrey, executive secretary of the Montgomery County Medical Society, served the committees as general chairman.

* * *

Many members were most favorably impressed by the splendid coverage of the entire two-days meeting by the Dayton newspapers. Accurate accounts were carried concerning the transactions of the House of Delegates and much space was given to the various scientific presentations, as well as to the annual addresses of the President and President-elect. The sentiment of the membership generally regarding the efficient manner in which the newspapers handled the meeting was expressed by the House of Delegates in adopting a motion expressing a vote of thanks to the Dayton papers and reporters assigned to the meeting.

* * *

Splendid cooperation and assistance were rendered the various committees who had a part in handling the details and arrangements for the meeting by the management of the Dayton-Biltmore Hotel and its courteous and hard-working employes. Everything possible for the convenience and accommodation of the visiting physicians was done by the hotel management, and because of the efficient way the hotel carried out its part of the arrangements, the committees were able to function effectively and speedily. Equally laudable was the treatment accorded the guests at the other hotels where meetings in connection with the meeting were held, namely: Miami, Gibbons, and Van Cleve.

* * *

Among the special get-to-gethers held during the meeting was a luncheon on Wednesday noon for Ohio members of the American College of Physicians at the Van Cleve Hotel. The luncheon, attended by 50 physicians, was arranged by Dr. A. B. Brower, Dayton, governor of the Ohio section, American College of Physicians. Those present decided to hold a similar meeting annually at the time of the annual meeting of the State Association.

Among those who attended the luncheon were:

Drs. F. C. Potter, D. B. Lowe, A. S. Robinson, Akron; C. W. Kirkland, Bellaire; J. E. Greiwe, Hiram B. Weiss, Cecil Striker, J. L. Tuechter, Oscar Berghausen, W. W. Klement, of Cincinnati; Howard Jones, Cireleville; H. V. Paryzek, C. W. Stone, C. L. Cummer, R. M. Watkins, J. P. Anderson, Willard C. Stoner, of Cleveland; G. T. Harding, Jr., J. M. Rector, R. A. Ramsey, Charles W. McGavran, J. J. Coons, E. F. McCampbell, of Columbus; A. B. Brower, Walter M. Simpson, Warren Breidenbach, E. E. Bohlender, Benedict Oleh, Webster S. Smith, Wallace Prugh, Michael R. Haley, C. R. Weis, C. D. Fife, of Dayton; Leo C. Bean, Gallipolis; H. C. King, Lakewood; Carl W. Sawyer, Marion; V. N. Marsh, Painesville; John T. Quirk, Piqua; Clement L. Jones, Springfield; R. R. Hendershott, Tiffin; Theodore Zhinden, C. S. Mundy, Karl D. Figley, Louis A. Levison, C. W. Waggoner, of Toledo, and W. H. Bunn, Youngstown.

* * *

Three Dayton luncheon clubs recruited three former presidents of the State Association to address them at their regular Tuesday noon luncheon meetings. Dr. J. H. J. Upham, Columbus, addressed the Civitan Club; Dr. L. L. Bigelow, Columbus, the Fellowship Club, and Dr. A. H. Freiberg, Cincinnati, the Optimists' Club.

* * *

Those who went to the trouble to obtain reduced-fare "certificates" when purchasing railroad tickets to Dayton were disappointed since not enough "certificates" were turned in at the Registration Headquarters to make the fare-and-a-half plan operable. Only 52 "certificates" were filed, the minimum number required by the carriers under the fare reduction plan being 100.

Cincy Homecoming Program

An interesting and varied program has been arranged for the annual reunion of the Medical Alumni Association, University of Cincinnati, on June 10 and 11.

On Friday and Saturday mornings, June 10 and 11, clinics will be presented at all the Cincinnati Hospitals. On Friday afternoon, the golf tournament will be held. Those desiring to play should send their names to Dr. Louis Feid, 1811 Union Central Building. The business meeting of the association will be held at 6 p. m. Friday, preceding the annual banquet at 7 p. m. at the Netherland-Plaza. A silver anniversary reunion of the Class of 1907 and the golden anniversary of the Class of 1882 will feature the banquet. Following the program, dancing and card playing is scheduled.

Right of the State Industrial Commission to rate employers on the basis of their safety records in computing the amount employers must contribute to the state workmen's compensation fund was upheld in a recent decision of the Ohio Supreme Court in a mandamus proceedings brought by the Powhatan Mining Company.

Organization Problems and Suggestions for Procedure Were Emphasized at Annual Organization Luncheon

Between 150 and 175 officers and committeemen of the State Association and the component county societies and academies of medicine attended the annual organization luncheon, given in their honor by the State Association, Tuesday noon, May 3, at the Hotel Gibbons.

Following the luncheon, Dr. D. C. Houser, the retiring president, welcomed the officers and committeemen, referring to them as "the chassis and running gears of the Ohio State Medical Association". He emphasized the fact that without the cooperation, loyalty and active interest of the great majority of members, medical organization in Ohio would be unable to function effectively for the best interest of the public and the medical profession, and that because so many members had devoted so much time and effort during the past year, the State Association had been able to add to its already splendid record of accomplishments.

Dr. Houser said that medical organization in Ohio is not standing still; that it is advancing because the "men in the field" are displaying a keen interest and taking an active part in the problems and affairs of medical organization. He pointed out, however, that someone must "do the driving and keep the machinery in running order". This task, Dr. Houser said, is the job of the officers and committeemen of the various county societies and academies and the officers and committeemen of the State Association. He congratulated the officers and committeemen of the component county societies generally on the splendid work they had done during the past year, despite unsettled economic and social conditions, and gave them the large share of credit for stimulating interest and enthusiasm among the membership which had made it possible for medical organization to forge ahead and function effectively.

Dr. Houser urged the continuation of active cooperation between the county officers and committeemen and the officers and committeemen of the State Association, and described briefly how both groups can assist each other in local, as well as state-wide questions. He also complimented those members who contribute frequently to scientific programs at county, district and state meetings, pointing out that while they may not necessarily be key-men in organization activities, they are playing an important part in one of the major phases of organization activities and are indispensable to medical organization.

To illustrate the point that medical organization is constantly advancing and that now, despite the economic situation, it is in an unusually strong position from the standpoint of membership and interest, Dr. Houser pointed out that 25 counties in the state had the same number of paid-up members on May 1, this year, as they had at the end of 1931. These counties are: Brown, Clark, Erie, Fulton, Gallia, Greene, Guernsey, Knox, Lake, Logan, Madison, Mercer, Monroe, Morgan, Noble, Ottawa, Portage, Preble, Putnam, Shelby, Sandusky, Union, Vinton, Wayne and Williams.

He also said that 11 counties in the state had more paid-up members on May 1, 1932, than they did at the end of 1931, namely: Ashland, Coshocton, Crawford, Delaware, Hocking, Holmes, Licking, Lorain, Medina, Paulding and Van Wert. Dr. Houser pointed out that seven other counties—Adams, Defiance, Fairfield, Meigs, Pike, Ross and Warren—had a 100 per cent membership record on May 1, 1932, in comparison with the paid-up membership at the end of 1931 but that each had lost one or more members through death or removal.

The President congratulated each of the county societies enumerated and expressed the hope that in the near future more names would be added to the membership rolls especially from the other counties and from among the present delinquent and eligible non-members.

A fine ovation was given Dr. H. M. Platter, the new president, when he was presented by Dr. Houser. Dr. Platter expressed his appreciation of the honor which had been conferred upon him and said that he well realized that he was addressing those who made the wheels of medical organization revolve. After briefly re-emphasizing and reiterating some of the important points made by Dr. Houser, he touched on some of the questions which medical organization must face during the coming year, making the prediction that if the same spirit of cooperation which has been demonstrated by the membership, and especially the officers and committeemen of the county societies, during the past year is continued, medical organization will be able to satisfactorily solve the great majority of important issues.

Dr. Platter spoke briefly on legislative matters and questions relative to law enforcement and law observance.

"The coming legislative year will be a strenuous one," he declared. "It will need harder work than its predecessors, but, if the spirit of cooperation which you have demonstrated in the past will continue, we should be able to defeat destructive legislation as applied to matters of medical practice and public health. Only though constant cooperation will this be possible.

"These are strenuous times when law enforcement and law observance is at a minimum—not only in America but in the world at large. Par-

ticularly, in the field of criminal procedure has law enforcement reached a low ebb. It is not necessary to recount the innumerable instances of this fact. They are known to each one of you and prevail in all communities. It is a legal axiom that no law, however good, is observed unless there is a strong active and preponderant local sentiment for its observance. And, perhaps, we can evolve a plan of procedure by which all county societies may be able to exercise enough pressure upon the officials who are, by law, required to prosecute the offenders to show them that organized medicine wants the laws enforced. I am sincerely of the belief that a procedure along this line will be productive of more good than any other. All cases must be brought locally and tried locally by officials elected locally. These officials are answerable to their constitutents and all of them wish to run on their records—not from them—when they come up for re-election."

Dr. Platter expressed the opinion that there has never been a time when medical organization must be better informed and more alert, or when cooperation will be able to show a better result.

"Our organization," he said, "contains men of high character and ability, good citizens, in every county in Ohio; men whose advice and counsel is sought on many other questions than the practice of healing. No body of men possesses more avenues by which they can disseminate authentic information on matters involving the good health of our people and no body of men can show a better record of achievement and can face the future and battle for the things we hold most dear with clearer consciences, than men of medicine whose ideals place service first."

In conclusion, Dr. Platter voiced his sincere desire to cooperate in every possible way with individual members and every county society, and assured those present, representing the different county societies, that "the new administration will battle for you" as had that of the past year and those of preceding years.

Dr. John B. Alcorn, Columbus, chairman of the Committee on Public Policy, was called upon by Dr. Houser to discuss some of the pending questions of policy and public relations confronting the State Association, especially problems in legislation and government, national, state and local.

Dr. Alcorn reviewed in a general way some of the numerous questions considered by the committee during the past year, calling attention to the fact that practically all of these had been discussed in detail in the annual report of the Committee on Public Policy, published in the May, 1932, issue of *The Journal*.

Commenting on the future, Dr. Alcorn said that he felt the next regular session of the State Legislature, in 1933, will be of unusual importance and seriousness because of the sudden and radical changes in public sentiment and the growing craze for all kinds of social service, subsidy and paternalistic legislation. For this reason, he pointed out, medical organization must start preparing now, through strong, united and harmonious organized effort, to meet the impending issues.

After enumerating in a general way some of the anticipated legislation during the next General Assembly, Dr. Alcorn stressed the fact that it is the duty and responsibility of every member of medical organization to take an active, personal interest in moulding public opinion in accordance with the fundamentally sound, concerted medical viewpoint on matters affecting public health, medical practice, scientific medicine and the social-economic status of physicians. He cited the varied contacts established by the Committee on Public Policy with different individuals, groups and organizations to illustrate how important it is for the medical profession to be accurately informed on such activities and problems, and to convey to such individuals and groups the medical viewpoint on questions in which physicians are primarily interested.

Regarding the function the officers and legislative committeemen of the county medical societies can perform in cooperation with the Committee on Public Policy, Dr. Alcorn declared the committee can do little without the support and especially the activity and cooperation of the county officers and committeemen. He pointed out that the vital, primary and all-important function in forming contacts with candidates for all public offices, especially with members of the State Legislature, lies with the members, officers and committeemen of the component county societies. Dr. Alcorn advocated strongly that all likely candidates, including those for re-election and those who are new candidates, be advised by their physician constituents not to pledge themselves in advance to any proposals, plausible as they may seem on their face, in any way affecting public health and medical practice, and that they be advised to look to the medical profession for correct and accurate information and counsel on such questions as they arise.

He pointed out that each legislative committeeman has definite responsibilities, one of which is the establishing of contact with candidates for public office; another, keeping the Committee on Public Policy and the State Headquarters promptly informed on local developments and on the reactions of members of the Legislature to various proposals, and still another, disseminating information and suggestions, not only to office holders and candidates, but to the members of his own county medical society.

In conclusion, Dr. Alcorn thanked the officers and committeemen who had given splendid cooperation to the committee in the past and expressed the hope that such cooperation and active interest would be strengthened and maintained.

Dr. J. E. Tuckerman, Cleveland, chairman of the

Committee on Medical Defense, reviewed briefly the highspots of the annual report of his committee, published in the May, 1932, issue of *The Journal*, emphasizing in particular that portion of the report which touched on some of the common causes of suits for alleged malpractice.

Dr. Tuckerman said that it would be impossible to repeat too often the statement that the great majority of threats and suits for alleged malpractice would never have arisen if some physician somewhere had not sown the seeds of discontent in the mind of some other physician's patient, perhaps through a careless or thoughtless remark, or perhaps in a spirit of jealousy or malice.

"It is strange," he said, "but there are still some physicians left who think that they can climb to success by knocking their colleagues and they usually are the ones responsible for the majority of the threats made and suits filed against physicians.

Dr. Tuckerman stressed the importance of keeping accurate records, referring to this as most important in the defense of a malpractice suit. He emphasized the importance of using the X-ray in fracture cases and keeping a complete file of plates, and the necessity of remaining in good standing at all times in medical organization through the prompt payment of dues. He also discussed a number of points relative to privileged communications; the statute of limitations, and service by physicians as expert witnesses.

In closing, Dr. Tuckerman advised any physician, if sued, not to discuss the suit or the facts of the case with anyone except his attorney and to remember that "any settlement at all is a bad settlement".

Closing the informal program, Dr. Gainor Jennings, West Milton, complimented Dr. Houser for his untiring and meritorious service during the past year and referred to him as an outstanding representative of the medical profesion generally, and especially of the rural general practitioners.

Dr. Jennings said he deplored unfounded charges which had been made during the past year by a few that medical organization is split up into urban and rural factions and that one or the other of these is occasionally discriminated against. He declared that he believed such allegations are unwarranted and that the medical profession is united on the important, fundamental policies which tend to promote scientific medicine and carry out the ideals of the profession.

Dr. Jennings urged county society officers and committeemen present to feel it their responsibility and duty to carry back to their members the messages obtained from the State Association officers and committeemen at this meeting, and particularly to study the annual reports of the State Association committees and urge their members to do likewise. He emphasized that above all, the county society officers should take an active part in medical organization activities and not depend only on the officers and committees of the State Association to keep the organization functioning. Dr. Jennings said the county officers should respond promptly to requests for information and assistance from the State Association officers and committees in order to make the entire program of medical organization in the field of legislation, and otherwise, effective. He pointed out that the medical profession is apt to become apathetic toward many serious questions and only to work as an effective unit when an emergency arises. This is wrong, Dr. Jennings said, pointing out that destructive forces are at work 365 days in the year and that physicians as leading citizens must at all times strive to strengthen their forces in order to overcome those forces inimical to scientific medicine.

The Attendance Record at the 86th Annual Meeting in Dayton

Attendance at the Eighty-Sixth Annual Meeting of the State Association at Dayton, May 3 and 4, was splendid, especially when compared with the decline in registration at similar professional and business gatherings throughout the state and nation.

Total registration at Dayton, including members of the State Association, guests and exhibitors was 1226, a somewhat smaller figure than that recorded at the last annual meeting held at Dayton, in 1923, when the total registration was 1414.

Members who attended and registered at Dayton totaled 978, compared to a total membership registration of 1117 in 1923.

The registration of guests, including interns, medical students and women visitors, totaled 201.

The number of exhibitors registered—45—was the smallest at any annual gathering held in the past 14 years, probably another reflection of business conditions generally.

Only two out-of-state physicians were registered, this being due, no doubt, to the fact that with one exception all the scientific presentations were made by Ohio physicians.

The following tabulation for the past succeeding 14 annual meetings shows by comparison the members registered in attendance, the out-of-

state physicians, the number of guests, exhibitors and respective totals:

Year and Meeting place	Members	Out of state Physicians	Guests	Exhibitors	Total
1919 Columbus	1173	10	264	92	1529
1920 Toledo	810	17	105	80	1062
1921 Columbus	1275	28	204	96	1503
1922 Cincinnati	1066	21	184	70	1341
1923 Dayton	1117	19	202	76	1414
1924 Cleveland	1301	13	180	109	1603
1925 Columbus	1204	17	361	107	1689
1926 Toledo	903	19	120	83	1125
1927 Columbus	1320	17	286	82	1705
1928 Cincinnati	916	27	92	80	1116
1929 Cleveland	1231	15	249	124	1619
1930 Columbus	1241	13	435	86	1775
1931 Toledo	826	13	198	50	1087
1932 Dayton	978	2	201	45	1226

MEMBERSHIP REGISTRATION

The list of members registered, by counties, follows:

Adams—S. J. Ellison, Hazel L. Sproull, O. T. Sproull, Ray Vaughen. *Allen*—(28)—M. R. Bixel, Rosella L. Biedermann, Ezra Burnett, R. D. Doughty, V. H. Hay, G. E. Jones, J. R. Johnson, G. E. Miller, Frank Morris, W. H. Parent, W. V. Parent, Edward B. Pedlow, George J. Roberts, A. S. Rudy, William Roush, W. D. Soash, O. S. Steiner, John J. Sutter, J. R. Tillotson, T. R. Thomas, H. A. Thomas, T. R. Terwilliger, F. B. Thutt, Herman M. Turk, W. H. Vorbau, A. N. Wiseley, John Wolfe, E. C. Yingling.

Ashland—W. F. Emery, L. G. Sheets. *Ashtabula*—R. B. Wynkoop. *Athens*—J. L. Henry, C. S. McDougall, A. L. Pritchard, C. von Scheele, John R. Sprague. *Auglaize*—Charles C. Berlin, Theodore A. Campbell, F. F. Fledderjohann, E. F. Heffner, R. C. Hunter, L. A. Kleinhenz, J. W. Laufersweiler, C. P. McKee, Walter A. Noble, Harry S. Noble.

Belmont—C. W. Kirkland, Lewis L. Liggitt, R. Maskrey Wilson. *Brown*—John G. Anderson. *Butler*—Charles T. Atkinson, E. O. Bauer, Hugh J. Baker, D. M. Blizzard, H. L. Burdsall, C. J. Chamberlin, W. F. Coakley, G. H. Cook, Mildred W. Gardiner, Wilmer E. Griffith, G. A. Hermann, William H. Henry, Ross A. Hill, G. D. Lummis, Harold O. Lund, Mark Millikin, H. S. Murat, Walter H. Roehll, Mildred Law Snyder, C. A. Spitler, E. T. Storer, H. N. Ward, Willis A. Whitman. *Champaign*—E. R. Earle, D. C. Houser, E. W. Ludlow, L. A. Woodburn, V. G. Wolfe, W. A. Yinger.

Clark—(28)—Roy D. Arn, F. P. Anzinger, I. H. Boesel, R. G. Boehme, W. E. Bright, J. E. Burgman, M. S. Collins, A. W. Detrick, C. W. Evans, C. E. M. Finney, R. S. Fidler, Albert K. Howell, Delos W. Hogue, S. R. Hutchings, Clement L. Jones, A. Richard Kent, G. M. Lane, J. A. Link, H. B. Martin, C. L. Minor, L. H. Mendelson, Wm. B. Quinn, C. S. Ramsey, J. D. Thomas, Benetta D. Titlow, Will Ultes, G. C. Ullery, G. D. Whitacre. *Clermont*—J. M. Coleman, Allan B. Rapp, G. S. Van Horn. *Clinton*—E. Briggs, Robert Conard, T. E. Craig, Glenn K. Dennis, L. H. Fullerton, Kelley Hale, V. E. Hutchens, C. E. Kinzell, Frank A. Peele, Wm. H. Regan, A. C. Roberts, Elizabeth Shrieves, C. A. Tribbet. *Columbiana*—Paul H. Beaver, Lea A. Cobbs, M. D. McCutcheon, V. E. McEldowney, E. W. Miskall, A. L. Turner. *Coshoeton*—Wilmer Hammond. *Crawford*—G. T. Wasson.

Cuyahoga—(54)—John P. Anderson, M. E. Blahd, C. A. Black, William Evans Bruner, C. D. Christie, Harold N. Cole, Milton B. Cohen, A. G. Cranch, C. L. Cummer, M. T. Donahue, J. R. Driver, V. H. Dredge, Wm. J. Engel, R. C. Engel, Lee H. Ferguson, Henry J. Gerstenberger, W. James Gardner, Leona V. Glover, Donald M. Glover, Frank S. Gibson, C. T. Hemmings, Henry J. John, Louis J. Karnosh, F. J. Kern, Benjamin S. Kline, H. C. King, C. G. LaRocco, George H. Lewis, S. Littman.

William E. Lower, Myron Metzenbaum, Paul G. Moore, S. H. Monson, Harry V. Paryzek, D. A. Prendergast, W. J. Quigley, J. R. Ripton, Albert D. Ruedemann, Henry C. Schumacher, R. G. Schnee, E. L. Sherrer, H. G. Sloan, David Steel, Herman C. Stevens, Walter G. Stern, Richard E. Stout, Willard C. Stoner, Charles W. Stone, G. F. Sykes, J. E. Tuckerman, John A. Toomey, Justin M. Waugh, Claude D. Waltz, R. M. Watkins.

Darke—W. D. Bishop, W. T. Fitzgerald, I. H. Hawes, E. G. Husted, F. M. Kissell, B. F. Metcalfe, John J. Moffett, J. S. Niederkorn, J. C. Poling, C. I. Stephen, J. O. Starr, Geo. F. Van Pelt, J. W. Van Lue, O. P. Wolverton. *Defiance*—G. W. DeMuth, Paul B. Newcomb, D. J. Slosser. *Delaware*—E. V. Arnold, W. E. Borden, A. R. Callander, M. S. Cherington, J. K. James, James G. Parker, C. F. Talley. *Erie*—F. M. Houghtaling.

Fairfield—C. G. Axline, George O. Beery, P. S. Bone, A. A. Brown, Carl W. Brown, W. R. Coleman, J. T. Farley, C. H. Hamilton, F. W. James, A. M. Kelley, R. W. Mondhänk, H. R. Plum, Ralph H. Smith, C. B. Snider, K. W. Taylor, William E. Wiyiarch. *Fayette*—J. M. Harsha, E. F. Todhunter, James F. Wilson, A. D. Woodmansee.

Franklin—(109)—J. B. Alcorn, A. A. Ahn, B. W. Abramson, K. H. Armen, H. M. Austin, James F. Baldwin, E. H. Baxter, Orville L. Baldwin, James A. Beer, L. L. Bigelow, H. E. Boucher, J. E. Briggs, Wayne Brehm, H. M. Brundage, Edward E. Campbell, Kenneth A. Clouse, Ivor G. Clark, E. H. Chapin, J. J. Coons, Andre Crotti, J. T. Craddock, H. H. Dorr, Verne A. Dodd, Morgan C. Davies, A. H. Dunn, J. M. Dunn, E. J. Emerick, S. D. Edelman, Earl W. Euans, John P. Farson, Jonathan Forman, T. R. Fletcher, Albert D. Frost, J. M. Gettrost, Emilie C. Gorrell, E. J. Gordon, S. J. Goodman, F. E. Ginder, H. D. Giles, John H. Hanes, Emery R. Hayhurst, Arthur M. Hauer, I. B. Harris, George T. Harding, Jr., George T. Harding, III, Frank W. Harrah, E. D. Helfrich, Arthur G. Helmick, E. G. Horton.

W. D. Inglis, David M. Johnson, George W. Keil, C. C. Kirk, Ben R. Kirkendall, F. F. Lawrence, Louis Mark, E. F. McCampbell, Charles W. McGavran, John H. Mitchell, H. R. Mitchell, Russel G. Means. Myron D. Miller. William F. Millhon, M. E. Millhon, Link A. Murphy, G. I. Nelson, Robert W. Nosker, W. E. Obetz, Claude S. Perry, Joseph Price, C. D. Postle, Earl F. Peinert.

H. M. Platter, C. O. Probst, H. L. Reinhart, E. Reinert, James M. Rector, R. A. Ramsey, J. A. Riebel, Andrews Rogers, C. C. Ross, Ernest Scott, C. E. Schilling, C. E. Sharp, E. R. Shaffer, C. M. Shepard, Charles J. Shepard, Wynne M. Silbernagel, Carl L. Spohr, C. H. Solomonides, A. M.

Steinfeld, M. E. Swinehart, John M. Thomas, F. W. Thomas, Wells Teachnor, Campbell Taylor, Erwin W. Troutman, Finley Van Orsdall, J. H. J. Upham, James H. Warren, M. Grace Welch, John J. Wenzke, Fred H. Weber, Howard Whitehead, P. B. Wiltberger, P. W. Willey, J. W. Wilce, C. H. Wyker, Frank C. Wright.

Gallia—Mary C. Austin, Leo C. Bean, S. L. Bossard, O. A. Vornholt. *Greene*—Marshall M. Best, A. D. DeHaven, C. W. Dawson, Paul D. Espey, Miron I. Marsh, W. C. Marshall, R. R. McClellan, Ben R. McClellan, C. G. McPherson, A. C. Messenger, H. C. Messenger, T. F. Myler, Harold E. Ray, Hugh C. Schick, C. K. Schloss, Lester W. Sontag, L. L. Taylor, A. N. Vandeman, Wm. T. Ungard, P. B. Wingfield. *Guernsey*—A. C. Ormond, Jr., B. A. Souders.

Hamilton—(104)—Floyd P. Allen, Eslie Asbury, J. F. Bateman, Oscar Berghausen, Ruth G. Bernheim, Julien E. Benjamin, D. J. Bradley, Samuel Brown, Albert L. Brown, Gerald H. Castle, Robert Carothers, Ralph G. Carothers, John A. Caldwell, A. T. Childers, R. L. Drudgington, Stanley Dorst, J. L. DeCourcy, Louis Feid, Jr., Carroll J. Fairo, Starr Ford, Jr., E. I. Fogel, Wesley L. Furste, Albert H. Freiberg, Joseph A. Freiberg, Henry B. Freiberg, R. E. Gaston, Mabel E. Gardner, Elizabeth B. Gillespie, Wm. P. Gillespie, Henry M. Goodyear, J. Victor Greenebaum, W. D. Haines, C. Haarlammert, Mortimer Herzberg, Louis J. Hendricks, Louis G. Heyn, Joseph D. Heiman, Charles A. Hofling, Robert E. Howard, Samuel Iglauer, Charles C. Jones, Lloyd B. Johnston, D. A. Johnston.

Charles E. Kiely, Allen T. King, M. W. Klement, C. A. Langdale, George Lyford, Donald J. Lyle, John J. Maloney, Charles J. McDevitt, J. W. McCammon, E. F. McKim, James W. Miller, E. W. Mitchell, John D. Miller, Wm. Mithoefer, Eli A. Miller, Myer S. Muskat, A. W. Nelson, Emerson A. North, Samuel Okrent, Wm. H. Peters, D. W. Palmer, Wm. D. Porter, J. O. Porter, T. A. Ratliff, Mont R. Reid, J. L. Ransohoff, Clyde S. Roof, Moses Salzer, Morris S. Schulzinger, E. A. Schlueter, H. H. Schulze, T. K. Selkirk, Otto J. Seibert, Reed A. Shank, C. E. Shinkle, E. B. Snyder, Parke G. Smith, E. O. Smith, S. K. Siebler, Charles M. Siegel, F. M. Solar, Howard L. Stitt, Joseph Stein, Henry Stanbery, Frank E. Stevenson, Cecil Striker, E. O. Swartz, Paul W. Sutton, M. A. Tate, Esther Bogen Tietz, J. L. Tuechter, A. R. Vonderahe, Harris H. Vail, Edward A. Wagner, H. B. Weiss, J. H. Wilms, C. E. Wooding, M. M. Zinninger, Samuel Zielonka, Mendel Zeligs, Karl G. Zwick.

Hancock—H. O. Crosby, John V. Hartman, Don C. Hughes, O. P. Klotz, D. J. King, A. E. King, J. H. Marshall. *Hardin*—D. H. Bowman, F. M. Elliott, R. C. McNeill, E. S. Protzman, R. G. Schutte, S. C. Smith. *Henry*—Frank M. Harrison. *Highland*—J. C. Bohl, Hugh W. Chaney, Charles C. Cropper, J. H. France. J. D. McBride, K. R. Teachnor. *Hocking*—H. M. Brooks, J. S. Cherrington.

Jackson—J. J. McClung, O. McLaughlin, W. R. Riddell. *Jefferson*—John Y. Bevan, Victor Biddle, Carl Goehring, S. J. Podlewski, E. H. Rea, M. H. Rosenblum, Albert E. Weinstein. *Knox*—F. C. Anderson, Robert C. Eastman, O. W. Rapp, Julius Shamansky. *Lake*—R. E. Gardner, V. N. Marsh. *Lawrence*—Chester A. Casey, W. Wilson Lynd, W. F. Marting, Anne D. Marting, V. V. Smith.

Licking—H. B. Anderson, H. A. Campbell, A. G. Crow, Carl E. Evans, G. A. Gressle, R. W. Jones, R. C. Mauger, E. A. Moore, Dale E. Roth. *Logan*—F. B. Kaylor, A. J. McCracken, C. K. Startzman. *Lorain*—Valloyd Adair, S. V. Burley, B. E. Garver, Maurice Rosenzweig, David Thomas.

Lucas—(31)—W. W. Beck, W. W. Brand, B. H. Carroll, Frank C. Clifford, Burt G. Chollett, Fred M. Douglass, Leo P. Dolan, Karl D. Figley, John Gardiner, Norris W. Gillette, E. B. Gillette, Robert S. Gillette, A. P. Hancuff, B. J. Hein, K. R. Howard, C. E. Hufford, R. E. Hughson, Jr., R. Kuebbeler, L. A. Levison, Charles Lukens, Martin Lorenzen, L. K. Maxwell, Carll S. Mundy, C. S. Ordway, Thomas L. Ramsey, A. H. Schade, Walter H. Snyder, Bernhard Steinberg, John F. Wright, C. W. Waggoner, Theodore Zbinden.

Mahoning—A. E. Brant, W. H. Bunn, Charles D. Hauser, B. B. McElhaney, Wm. M. Skipp. *Madison*—R. W. E. Irwin, F. E. Rosnagle. *Marion*—C. L. Baker, E. L. Brady, D. W. Brickley, Bret B. Hurd, S. W. Mattox, James W. McMurray, Carl W. Sawyer, T. H. Sutherland. *Medina*—C. A. Bolich, E. L. Crum, M. F. Miller, Harry Street, Joseph G. Whitacre. *Meigs*—P. A. Jividen. *Mercer*—Frank E. Ayers, M. L. Downing, M. R. Fishbaugh, L. M. Otis, R. E. Riley, D. H. Richardson, J. P. Symons, J. O. Wickerham.

Miami—(31)—John Beachler, M. M. Brubaker, Warren Coleman, Russell Gardner, S. S. Gabriel, G. J. Hance, C. A. Halderman, E. R. Hiatt, Burton M. Hogle, Gainor Jennings, H. W. Kendell, Foster D. Kiser, I. C. Kiser, R. L. Kunkle, L. N. Lindenberger, G. E. McCullough, Maurice I. Miller, James E. Murray, H. R. Pearson, E. T. Pearson, E. G. Puterbaugh, C. F. Puterbaugh, John T. Quirk, L. A. Ruhl, D. W. Shellabarger, Robert D. Spencer, W. W. Trostel, Wm. W. Weis, G. A. Woodhouse, Ralph D. Yates, E. A. Yates.

Montgomery—(183)—R. W. Adkins, Elmer R. Arn, W. M. Ankeney, H. W. Angell, R. C. Austin, Sterling H. Ashmun, F. G. Barr, C. O. Bayless, G. W. Beeghley, Stanley M. Beck, B. W. Beatty, E. E. Bechtell, R. H. Bechtel, R. S. Binkley, W. J. Blackburn, A. L. Biggs, C. C. Borden, R. R. Bond, E. E. Bohlender, A. T. Bowers, L. G. Bowers, Warren C. Breidenbach, A. B. Brower, L. E. Brown, W. B. Bryant, H. W. Burnett, O. B. Burke, C. E. Burgett, R. A. Bunn, F. P. Bucher, R. O. Cass, Homer D. Cassel, John L. Carter, A. W. Carley, W. G. Clagett, C. N. Chrisman, D. B. Conklin, M. E. Coy, Lloyd H. Cox, L. R. Courtright, R. F. Corwin, A. D. Cook, Damon A. Crist, E. R. Crew, A. M. Culler, R. D. Dooley, C. J. Derby, W. H. Delscamp, W. E. Dapp, H. V. Dutrow, A. H. Dunham, E. J. Duffy, F. J. Driscoll, Eleanora S. Everhard, E. C. Fischbein, R. K. Finley, C. D. Fife, Gertrude Felker, Alfred G. Farmer, J. D. Fouts, Fredericka Freytag, Clarence L. Fraas, George Goodhue, G. D. Gohm, Curtiss Ginn, G. C. Gilfillen, Guy G. Giffin, P. L. Gunckel, H. C. Hanning, M. R. Haley, O. B. Hall, Harry H. Hatcher, F. W. Harris, Harry B. Harris, A. E. Hewitt, S. E. Hendren, H. H. Hermann, J. K. Hoerner, G. A. Hochwalt, N. C. Hochwalt, W. Richard Hochwalt, E. L. Hooper, R. D. Hostetter, C. W. Holtzmuller, C. A. Hueneke, E. M. Huston, Charles T. Hunt, H. R. Huston, J. W. Irwin, Lynn M. Jones, H. M. James, J. A. Judy.

Fred K. Kislig, P. H. Kilbourne, T. K. Kirk, P. A. Kemper, B. W. D. Keever, C. E. Kerney, J. H. Koehler, H. F. Koppe, Thurman H. Lautenschlager, W. F. Lauterbach, Kenneth Kurtz, A. F. Kuhl, N. E. Leyda, Raymond A. Lewis, Lee S. Lenz, E. W. Longnecker, M. M. Linder, J. B. Lloyd, E. B. Markey, J. Grant Marthens, W. B. Mansur, V. H. Mahan, W. C. Madden,

C. C. McLean, J. Lillian McBride, R. C. McNelly, D. C. Mills, J. W. Millette, D. E. Miller, H. C. Mundhenk, T. E. Newell, Benedict Olch, P. H. O'Hara, A. O. Peters, E. F. Pfanner, Foy C. Payne, C. D. Padan, C. C. Payne, W. S. Powell, Matthew Porter, Lydia L. Poage, R. E. Pumphrey, M. D. Prugh, W. E. Prugh, R. J. Price, Harry W. Reck, William Roehm, W. H. Riley, Wilbur A. Ricketts, F. V. Richie, C. B. Rogers, B. A. Rose, James Sagebiel, Leo Schram, Paul J. Shank, M. M. Shafer, E. W. Shank, C. E. Shepard, W. L. Slagle, O. H. Stuhlman, F. I. Shroyer, F. K. Shively, E. A. Sherk, T. C. Sheridan, A. F. Shepherd, J. D. Spaid, H. Snow, Webster S. Smith, C. Sidney Smith, J. D. Smith, C. D. Smith, E. McCall Smith, H. A. Slusser, Walter M. Simpson, C. D. Slagle, W. L. Slagle, L. L. Spitler, R. H. Spitler, G. E. Strahler, H. H. Stafford, J. J. Stout, H. L. Strohmeyer, Charles P. Sullivan, Ben F. Suffron, C. H. Tate, W. B. Taggart, J. D. Varney, E. R. Werner, C. R. Weis, W. Burnet Weaver, W. E. Wilmerding, Charles R. Wine, J. D. Wonder, Paul L. Yordy.

Monroe—H. P. Gillespie. *Morrow*—Frank M. Hartsook. *Muskingum*—R. B. Bainter, Edmund R. Brush, W. D. Coffman, O. I. Dusthimer, A. H. Gorrell, Beatrice T. Hagen, A. C. Lawrence, M. A. Loebell, Robert S. Martin, W. A. Melick. *Pickaway*—D. V. Courtright, Howard Jones, H. D. Jackson, J. A. Knight. *Ottawa*—F. E. Miller, C. J. Yeisley. *Pike*—I. P. Seiler, L. E. Wills. *Portage*—S. U. Sivon, Wm. J. Thomas.

Preble—W. G. Brown, W. I. Christian, G. W. Flory, C. H. Harris, A. C. Hunter, R. H. Jones, J. B. Lucas, C. E. McKinley, J. I. Nisbet, C. E. Newbold, J. C. Ryder, E. P. Trittschuh, C. M. Treffinger. *Putnam*—E. Blackburn, C. O. Beardsley, P. D. Bixel, B. E. Watterson, J. D. Watterson. *Richland*—Carl R. Damron, L. C. Nigh, Stanley C. Schiller, O. H. Schettler, J. A. Yoder. *Ross*—R. E. Bower, George W. Cooper, A. E. Merkle, George S. Mytinger, David A. Perrin, M. V. Scholl, Samuel M. Sproat, O. P. Tatman, J. S. Wiltshire.

Sandusky—W. H. Booth, J. L. Curtin, F. M. Kent. *Scioto*—Clyde M. Fitch, J. W. Fitch, A. P. Hunt, George W. Martin, Gilbert Micklethwaite, G. E. Neff, Joseph S. Rardin, Wm. E. Scaggs, Oral D. Tatje. *Seneca*—C. I. Anders, Robert Chamberlain, Charles F. Daniel, R. R. Hendershott, Roswell F. Machamer, Victor L. Magers, E. H. Porter, T. T. Rosendale. *Shelby*—Herman C. Clayton, A. B. Gudenkauf, Kenneth G. Hauver, H. A. Lindsay, F. R. McVay, O. O. LeMaster, Brent A. Welch.

Stark—(19)—S. B. Berkley, H. H. Bowman, J. P. DeWitt, Verl Z. Garster, Emerson Gillespie, Fred Hise, George S. Hackett, Perry F. King, George L. King, Jr., Edward M. Feiman, John D. O'Brien, C. A. Portz, R. K. Ramsayer, H. M. Schuffell, D. D. Shontz, L. D. Stoner, F. S. Van Dyke, A. W. Warren, George F. Zinninger.

Summit—(25)—R. E. Amos, O. J. Chaney, H. Irving Cozad, F. H. Cook, Harry S. Davidson, R. S. Friedley, R. A. Gregg, Walter A. Hoyt, C. L. Hyde, D. B. Lowe, George M. Logan, R. H. Markwith, D. M. McDonald, S. Morgenroth, R. C. Potter, E. C. Pickard, Andrew S. Robinson, John H. Selby, U. D. Seidel, H. Vern Sharp, J. E. Springer, Carl R. Steinke, A. D. Traul, Joseph M. Ulrich, L. A. Witzman.

Tuscarawas—Paul J. Alspaugh, H. A. Coleman, R. J. Foster, B. A. Marquand, C. J. Miller, E. D. Moore, George L. Sackett, E. B. Shanley, J. M. Smith. *Union*—John Dean Boylan, Fred Callaway, E. J. Marsh, C. D. Mills, James M. Snider, H. G. Southard. *Van Wert*—C. G. Church, F. W. Dannecker, S. A. Edwards, Roland H. Good, A. H. Hattery, A. T. Rank, J. B. Sampsell.

Warren—Edward Blair, Mary L. Cook, N. A. Hamilton, Wm. J. Mockler, Leonard Mounts, Edward C. Morey, S. S. Stahl, P. W. Tetrick. *Wayne*—E. H. McKinney, R. C. Paul, A. C. Smith, O. P. Ulrich, Vincent C. Ward. *Williams*—D. S. Burns, C. G. Goll. *Wood*—E. D. Foltz, W. W. Mannhardt, E. A. Powell, D. B. Spitler, H. E. Ward. *Wyandot*—J. Craig Bowman.

Medical Golfers Enjoyed Ideal Conditions at Annual Tournament in Dayton, May 2

The beautiful Dayton Country Club was the site of the Twelfth Annual Tournament of the Ohio State Medical Golfers Association. The rolling hills of the fairways, the well-placed traps and bunkers, and the tricky, fast greens tested the skill of about 70 golfers. The day, Monday, May 2, was ideal for play.

Dr. L. M. Otis, Celina, Ohio, is the new Champion and he turned in a gross score of 161 for 36 holes of good golf to win the much coveted trophy. Dr. H. L. Wenner, Jr., Toledo, champion for the last two years has moved from the state within the past month, and was not present to defend his title.

Dr. C. A. Hyer, Columbus, with a score of 162, was a close runner-up in the championship flight, while third place went to Dr. H. L. Furste, Cincinnati, with a gross score of 168 for the 36 holes of play.

The Association Handicap Championship for the lowest 27 hole net score was won by Dr. E. C. Yingling, Lima, with a score of 101. Second and third prizes in this event went to Drs. V. L. Magers, Tiffin, and C. F. Wharton, Akron.

The President's Trophy, presented by Dr. Chas. Lukens, was won by Dr. E. R. Marker, Toledo, with a low net score of 68 for the first eighteen holes of play. This event was limited to players with a handicap of 18 or under.

Dr. W. R. Riddell, Jackson, won the prize awarded for the low gross score for the first 18 holes of play.

Other Events and Prize Winners were as follows:

Low Net, Second 18 Holes—Dr. A. C. Smith, Wooster.

Low Gross, Second 18 Holts—Dr. L. Mark, Columbus.

Low Net, First 9 Holes—Dr. C. F. Daniell, Tiffin; second place—Dr. R. C. Chamberlain, Tiffin.

Low Gross, First 9 Holes—Dr. J. D. Fouts, Dayton, and Dr. R. F. Machamer, Tiffin, were in a tie with a score of 41, being awarded 1st and 2nd prizes.

Low Gross, Second 9 Holes—Dr. O. P. Tatman, Chillicothe, and Dr. R. W. Nosker, Columbus, were in a tie with a score of 43. They took 1st and 2nd place prizes.

Low Net, Second 9 Holes—Dr. A. N. Wiseley, Lima; second place—a tie between Dr. J. P. DeWitt, Akron; O. A. Vornholt, Gallipolis, and W. W. Sauer, Marietta.

Low Gross, Third 9 Holes—Dr. W. E. Dwyer, Cleveland; second—Dr. D. Thomas, Lorain.

Low Net, Third 9 Holes—Dr. G. Micklethwaite, Portsmouth; second—Dr. L. C. Bean, Gallipolis.

Grand-dads Prize (Low Gross, 27 Holes, by players over 50 years of age)—Dr. R. A. Bunn, Dayton; second—Dr. H. M. Shuffel, Canton.

Team Championship—Won by Akron players. (Low Gross score 36 Holes—5 players).

High Gross Championship — Twenty-seven Holes—Dr. V. H. Hay, Lima.

Officers elected for the coming year at the golf banquet Monday evening, are as follows:

President—Dr. J. P. DeWitt, Canton, Ohio.

1st Vice-President—Dr. F. T. Gallagher, Cleveland, Ohio; 2nd Vice-President—Dr. J. L. McEvitt, Akron, Ohio; 3rd Vice-President—Dr. F. C. Haney, Columbus, Ohio; 4th Vice-President—Dr. J. F. Wright, Toledo, Ohio; 5th Vice-President—Dr. E. C. Yingling, Lima. Ohio.

Secretary-Treasurer—Dr. J. B. Morgan, Cleveland, Ohio.

Resume of Play

Following are the gross scores and handicap of the players participating in the 36-hole tournament:

	First Nine	Second Nine	Handicap
L. D. Stoner, Canton	58	50	25
	51	55	
S. L. Agnone, Canton	51	54	20
	45	50	
H. M. Shuffel, Canton	47	46	20
	44	45	
E. Feinman, Canton	52	54	25
	48	50	
R. F. Machamer, Tiffin	41	42	14
	44	46	
R. C. Chamberlain, Tiffin	47	51	25
	48	54	
V. L. Magers, Tiffin	46	45	22
	44	45	
C. F. Daniell, Tiffin	43	53	25
	48	50	
O. P. Tatman, Chillicothe	48	43	17
	49	46	
G. Micklethwaite, Portsmouth	50	51	25
	44	50	
F. C. Calloway, Marysville	50	55	22
	51	47	
R. C. Mauger, Newark	55	54	24
	50	53	
E. C. Yingling, Lima	45	43	18
	40	45	
A. N. Wiseley, Lima	47	45	25
	45	47	
L. M. Otis, Celina	41	42	12
	37	41	
E. J. Curtis, Lima	52	52	22
O. S. Steiner, Lima	53	63	25
	55	54	
J. R. Johnson, Lima	62	62	25
	56	53	
P. F. King, Alliance	48	51	20
	52	49	
G. S. Hackett, Canton	52	50	25
	44	48	
E. Gillespie, Canton	54	49	20
	46	45	
S. B. Berkley, Canton	55	46	15
	50	46	
J. P. DeWitt, Canton	51	46	24
	47	47	
C. W. McGavran, Columbus	48	50	20
A. Timberman, Columbus	55	58	25
D. A. Crist, Dayton	53	57	25
W. W. Sauer, Marietta	46	44	20
V. Adair, Lorain	47	48	18
	48	53	
J. R. Ripton, Cleveland	59	58	24
D. Thomas, Lorain	46	48	18
	43	52	
B. E. Garver, Lorain	52	53	20
	48	50	
J. D. Fouts, Dayton	41	43	6
	45	45	
L. Mark, Columbus	44	45	7
	40	39	
M. R. Haley, Dayton	44	53	18
	44	54	
R. W. Nosker, Columbus	47	43	12
	45	43	
D. C. Brennan, Akron	47	45	12
	46	47	
J. B. Morgan, Cleveland	58	53	20
	52	52	
J. L. McEvitt, Akron	44	51	10
	47	55	
F. T. Gallagher, Cleveland	45	44	12
	53	47	
H. L. Furste, Cincinnati	42	41	9
	40	45	
F. C. Haney, Columbus	45	48	18
	49	45	
C. A. Hyer, Columbus	39	41	10
	40	42	
W. E. Dwyer, Cleveland	47	53	15
	40	54	
D. B. Lowe, Akron	53	53	22
	50	54	
D. M. McDonald, Akron	48	54	22
	50	54	
S. Morganroth, Akron	50	47	12
	50	48	
N. W. Gillette, Toledo	47	47	23
	47	49	
E. R. Marker, Toledo	42	40	14
	43	42	
Chas. Lukens, Toledo	51	47	20
	49	49	
J. F. Wright, Toledo	51	58	25
	53	56	
E. L. Brady, Marion	52	53	20
	56	57	
J. B. Sampsell, Van Wert	46	50	12
	48	53	
L. C. Bean, Gallipolis	49	44	20
	44	46	
G. W. Martin, Portsmouth	59	50	25
	55	54	
W. R. Riddell, Jackson	42	40	10
	39	50	
O. A. Vornholt, Gallipolis	47	44	20
	47	45	
J. E. Talbot, Lima	52	49	25
	51	53	
V. H. Hay, Lima	62	58	25
	64	54	
H. A. Thomas, Lima	54	56	25
	60	54	
E. H. Hedges, Lima	57	56	24
	51	56	
H. V. Dutrow, Dayton	51	55	24
	49		
H. H. Hatcher, Dayton	49	53	23
	49		
P. Tappan, Dayton	49	51	25
	50		
F. Thomas, Columbus	49	50	20
	50		
O. Baldwin, Columbus	50	56	25
	58		
C. F. Wharton, Akron	43	42	16
	41	45	
R. E. Amos, Lorain	60	58	25
	62	59	
R. A. Bunn, Dayton	45	45	16
	42	48	
A. C. Smith, Wooster	46	46	19
	44	40	

Ohio Physicians Had Prominent Part in A.M.A. Meeting at New Orleans

Approximately 100 Ohio physicians attended the Eighty-Third Annual Meeting of the American Medical Association at New Orleans, May 9 to 13.

Ohio physicians as usual took an active part in the business and scientific activities of the meeting.

The Ohio State Medical Association was ably represented in the House of Delegates by Drs. C. W. Stone, Cleveland; Ben R. McClellan, Xenia; Wells Teachnor, Sr., Columbus; John P. DeWitt, Canton; Charles E. Kiely, Cincinnati; Dr. C. L. Cummer, Cleveland, alternate for Dr. E. R. Brush, Zanesville, and Dr. George F. Zinninger, Canton, alternate for Dr. C. W. Waggoner, Toledo.

Dr. Teachnor served as a member of the important House of Delegates reference committee on reports of the Board of Trustees and Secretary of the A.M.A.

Dr. J. H. J. Upham, Columbus, member of the Board of Trustees and a member of the Committee on Scientific Exhibit, and Dr. Geo. Edw. Follansbee, Cleveland, chairman of the Judicial Council, took prominent and active parts in the official proceedings.

Dr. Upham reported for the Board of Trustees to the House of Delegates on many matters, as did Dr. Follansbee for the Judicial Council.

In a special report submitted by Dr. Follansbee to the House of Delegates for the Judicial Council, and adopted, a protest was voiced against the practices of some lay bodies, insurance companies and some universities for competition with the medical profession. The report cited as examples of such unfair practices the following:

"There are insurance companies administering workmen's compensation benefits wherein the salaries or fees paid to the physician by the insurance company are so much below the legal fees upon which the premium paid by the industry is based as to furnish a large direct profit to the insurance company.

"Certain hospitals are forbidding their staff physicians to charge fees for their professional services to 'house cases' but are themselves collecting such fees and absorbing them in the hospital income.

"Some universities by employing full-time hospital staffs and opening their doors to the general public, charging such fees for the professional care of the patients as to net the university no small profit, are in direct and unethical competition with the profession at large and their own graduates. They are making a direct profit by a practice of questionable legality from the professional care."

One of the important resolutions adopted by the House of Delegates recommended a requirement that all staff members of hospitals approved for intern training must be members of their local county medical society and the state association.

Questions relative to veterans' relief and legislation were considered at length by the House of Delegates which authorized the Board of Trustees, the Bureau of Legal Medicine and Legislation and the special Auxiliary Committee on Veterans' Legislation to continue with conferences on these problems with representatives of the government and veterans' organizations in an effort to work out a program for the best interests of all concerned.

At the final session of the House of Delegates, Dr. Dean D. Lewis, professor of surgery, Johns Hopkins University, Baltimore, was elected president-elect of the A.M.A. and Dr. E. H. Cary, Dallas, was installed as president, succeeding Dr. E. Starr Judd, Rochester, Minnesota.

Dr. Rudolph Matas, New Orleans, was named vice-president, and the following were re-elected: Dr. Olin West, Chicago, secretary and general manager; Dr. Austin A. Hayden, Chicago, treasurer; Dr. F. C. Warnshuis, Grand Rapids, speaker of the House of Delegates, and Dr. Albert E. Bulson, Fort Wayne, vice-speaker. Dr. Arthur W. Booth, Elmira, New York, was elected a member of the Board of Trustees, succeeding Dr. Edward B. Heckel, Pittsburgh, who retired after many years of service on the board, the last seven years of which he had served as chairman. Dr. Rock Sleyster, Wauwatosa, Wisconsin, was re-elected a member of the board, which named Dr. A. R. Mitchell, Lincoln, Nebraska, chairman, succeeding Dr. Heckel.

Milwaukee was chosen by the House of Delegates as the place for the 1933 meeting of the A.M.A., receiving 73 votes to Cleveland's 44 and Atlantic City's 11.

Among Ohio physicians who took part in the scientific program as essayists, discussants, lecturers, exhibitors, demonstrators or officers of scientific sections were:

Benjamin S. Kline, Cleveland; W. James Gardner, Cleveland; H. F. DeWolfe, Cleveland; J. V. Van Cleve, Cleveland; Herbert A. Wildman, Wooster; Russell L. Haden, Cleveland; Edward D. King, Cincinnati; Howard L. Stitt, Cincinnati; Samuel Iglauer, Cincinnati; Morris Gruenebaum, Cincinnati; Robert Howard, Cincinnati; A. Graeme Mitchell, Cincinnati; L. A. Lurie, Cincinnati; J. V. Greenebaum, Cincinnati; E. A. North, Cincinnati; E. R. Hayhurst, Columbus; Paul A. Davis, Akron; Edgar C. Baker, Youngstown; J. S. Lewis, Jr., Youngstown; Harold Feil, Cleveland; Charles S. Higley, Cleveland; Eslie Asbury, Cincinnati; H. Kennon Dunham, Cincin-

nati; R. S. Dinsmore, Cleveland; E. R. Arn, Dayton; T. E. Jones, Cleveland; D. T. Vail, Jr., Cincinnati; William V. Mullin, Cleveland; Henry J. Gerstenberger, Cleveland; Henry J. John, Cleveland; Elmore B. Tauber, Cincinnati; Harold N. Cole, Cleveland; Torald H. Sollmann, Cleveland; Nora Schreiber, Cleveland; J. Edgar Fisher, Cleveland; Geo. Edw. Follansbee, Cleveland; Willard C. Stoner, Cleveland; Wallace S. Duncan, Cleveland; James A. Dickson, Cleveland; B. J. Hein, Toledo; Rudolph S. Reich, Cleveland; Robert Carothers, Cincinnati.

Ohioans carried away several of the big prizes in the annual tournament of the American Medical Golfing Tournament, held on Monday, May 9 at the New Orleans Country Club.

Dr. A. C. Smith, Wooster, won first prize for the third time for low net for 36 holes. Dr. L. E. Leavenworth, Canton, took third place, and Dr. S. B. Berkley, Canton, tied for fourth place in this division.

The Thomas trophy for low net, 18 holes, was won by Dr. H. H. McClellan, Dayton. Dr. J. P. DeWitt, Canton, won the Copper State trophy awarded for low net, 18 holes, by players 60 years of age or more.

Among Ohio physicians in attendance and registered were:

Cincinnati—(19)—Ira A. Abramson, Eslie Asbury, Mary Knight Asbury, Robert Carothers, S. Bertha Dauch, Max Dreyfoos, Kennan Dunham, Ralph W. Good, J. Victor Greenebaum, Louis G. Heyn, Mortimer Herzberg, Charles E. Kiely, Arthur L. Knight, Albert Graeme Mitchell, Rogers S. Morris, Helena T. Ratterman, Elmore B. Tauber, Derrick T. Vail, Jr., M. M. Zinninger.

Cleveland—(23)—John P. Anderson, Milton B. Cohen, Harold M. Cole, Clyde L. Cummer, Henry F. DeWolf, James A. Dickson, Wallace S. Duncan, Geo. Edw. Follansbee, N. James Gardner, Russel L. Haden, Henry J. John, Thomas E. Jones, Benjamin S. Kline, Robert J. May, E. Perry McCullagh, Forrest W. Merica, Rudolph S. Reich, A. G. Schlink, Harry A. Schlink, Robert M. Stecher, C. W. Stone, Willard C. Stoner, Norman C. Yarian.

Columbus—(10)—A. A. Ahn, C. I. Britt, Walter H. Hamilton, George B. Nessley, A. A. Peasley, Wells Teachnor, Sr., E. W. Troutman, J. H. J. Upham, Thomas A Vogel, Frank Warner.

Akron—Paul A. Davis. *Canton*—John P. DeWitt, L. E. Leavenworth, Edward O. Morrow, Homer V. Weaver, George F. Zinninger. *Chillicothe*—John W. Franklin. *Corning*—R. D. Book.

Dayton—Elmer R. Arn, M. E. Coy, Harry H. McClellan, F. C. Payne, Walter M. Simpson, Henry Snow. *Fremont*—Edgar M. Ickes, Frank L. Moore. *Grand Rapids*—Daniel R. Barr. *Leetonia*—Paul H. Beaver. *Mansfield*—Carl R. Damron. *Middletown*—David F. Gerber, E. T. Storer. *Miamisburg*—Charles T. Hunt. *Montpelier*—Harry W. Wertz. *North Canton*—S. B. Berkley. *Portsmouth*—H. M. Keil. *Salem*—L. A. Cobbs. *Sandusky*—Frederick Kenan, *Swanton*—L C. Cosgrove. *Toledo*—John T. Murphy, Lewis F. Smead.

Xenia—Ben R. McClellan, Reyburn McClellan. *West Union*—Ray Vaughen. *Wilmington*—Kelley Hale, V. E. Hutchens. *Wooster*—Alonzo C. Smith, H. D. Wildman. *Youngstown*—Edgar C. Baker, Morris Deitchman, Edward C. Goldcamp, John S. Lewis, Jr.

"Radio pillows", small receiving sets encased in sponge rubber with an outlet to permit undisturbed reception, with individual volume control, are to be installed at all beds of 105 army hospitals, the War Department has announced. Programs will be distributed from a central receiving station in each hospital.

TOO MANY NURSES, SURVEY SHOWS

Training schools must curtail the steady production of more nurses or the morale of the nursing profession will break down completely, in the opinion of the Committee on the Grading of Nursing Schools.

How serious the oversupply of graduate nurses has become is revealed by the Grading Committee after tabulating figures for eighteen states and the District of Columbia. For this group, since the 1920 census, the total population has increased 7 per cent, while the total number of trained nurses has increased 78 per cent.

A survey of 42 cities shows that the average nurse has no more than 149 days of employment in any given year. States as a whole are somewhat less oversupplied with nurses, although in New Hampshire the nurse can expect no more than 190 days of work in the year, and in Maine, Vermont, Iowa, North Dakota, South Dakota, Kansas, Delaware, Montana, Wyoming, Arizona, Nevada, Idaho and the District of Columbia there is not nearly enough nursing to be divided between the trained and untrained nurses competing for patients.

Untrained nurses are not on the increase, census figures show, but trained nurses are being turned out to terrific competition by the thousands each year.

The State Industrial Commission may be named a party defendant in an action against a nonparticipating employer in the workmen's compensation fund when the employer contends he has not sufficient funds to pay a judgment against him for injuries sustained by one of his employes, Common Pleas Judge Charles A. Leach ruled in a recent suit filed at Columbus. Judge Leach ruled in effect, that in case a judgment should be obtained by an injured workman in such event, the industrial commission is responsible for seeing that the compensation is paid, either from the funds of the commission or in a subsequent judgment obtained by the commission from the delinquent contractor.

Dayton—The Dayton League of Women Voters was addressed recently by Dr. Carl A. Wilzbach, Cincinnati, on "The Prevention and Control of Venereal Diseases".

Willard—Dr. D. W. McCreight, formerly of Willard, has joined the medical staff of the General Hospital, Long Branch, New Jersey.

Miamisburg—Dr. G. K. Butt has been appointed city physician by the city council.

Cincinnati—Annual meeting of the Association of Pennsylvania Railway Surgeons will be held in Cincinnati, next October 27 and 28, Dr. Ralph G. Carothers, president of the association, has announced.

Deaths in Ohio

Herman Bamberger, M.D., Toledo; Kentucky School of Medicine, Louisville, 1898; aged 65; died April 6 after an extended illness. He had retired 12 years ago because of ill health. Dr. Bamberger was a member of B'Nai B'Rith, Woodmen of the World, and Bayern Society. Surviving are his widow, one daughter and two sisters.

Charles L. Bonifield, M.D., Cincinnati; Medical College of Ohio, Cincinnati, 1886; aged 69; member of the Ohio State Medical Association and a fellow of the American Medical Association; died April 23 following a cerebral hemorrhage. Dr. Bonifield, former president of the Ohio State Medical Asociation (1907-08), was a prominent figure in professional, social, civic and political affairs of Cincinnati. He was born on a farm in Muskingum County and following his graduation from medical school spent several years abroad in study. From 1893 to 1898, Dr. Bonifield was clinician at the Medical College of Ohio and later was named clinical professor of gynecology at that institution. In 1910 he was made professor of gynecology and head of that department at the College of Medicine, University of Cincinnati. Dr. Bonifield was a past president of the Cincinnati Academy of Medicine and of the American Association of Obstetricians, Gynecologists and Abdominal Surgeons; a member of the Southern Surgical Association and the Cincinnati Obstetrics Society; editor of *The Journal of Medicine* (Cincinnati); head of the department of gynecology, Cincinnati General Hospital and a member of the staff at Christ Hospital. Dr. Bonifield had always taken an active interest in the civic and political affairs of Cincinnati. He was one of the early members and a past president of the Cincinnati Automobile Club and had served as president of the Ohio State Automobile Association, the American Automobile Association, and the Dixie Highway Association. Dr. Bonifield was keenly interested in politics. In 1921 he was defeated for mayor of Cincinnati by a small margin. Surviving are one son, Charles L. Bonifield, Jr., a student at the University of Florida, and one daughter, Miss Mabel Bonifield, who made her home with her father.

Arnold Cohen, M.D., Cleveland; Cleveland College of Physicians and Surgeons, 1898; aged 59; member of the Ohio State Medical Association and Fellow of the American Medical Association; died April 5. Dr. Cohen, a native of Wilkes-Barre, Pa., had practiced in Cleveland for the past 34 years. He is survived by his widow.

Firman R. Evans, M.D., Franklin; Miami Medical College, Cincinnati, 1873; aged 80; died April 5 at the Miami Valley Hospital, Dayton, of coronary occlusion and gastric ulcer. Dr. Evans began the practice of medicine in Franklin almost 60 years ago, his father and his grandfather having practiced there. He is survived by two sons, Dr. Rice Evans and Pierce Evans, both of Dayton.

Oliver R. Eylar, M.D., Waverly; Starling Medical College, Columbus, 1900; aged 71; member of the Ohio State Medical Association and of the American Medical Association; died April 17 following a stroke of apoplexy. Dr. Eylar had been health commissioner of Pike County since 1925. He is survived by two sons, two brothers and three sisters.

Adolphus B. Frame, M.D., Piqua; Medical College of Ohio, Cincinnati, 1868; member of the Ohio State Medical Association and a Fellow of the American Medical Association; aged 92; died April 11 of heart trouble. Dr. Frame, one of the oldest physicians in Ohio in active practice, was born at Coolville, Athens County. Dr. Frame's college career at Marietta College was interrupted by the Civil War in which he served three years as a member of Company I, 166th Regiment, Ohio Volunteer Infantry, being mustered out as a captain. Following the war, he entered medical school and upon graduation practiced in Coolville and Athens. In 1887, Dr. Frame moved to Piqua. He maintained an active interest in military activities and in 1928 was elected commander for Ohio of the Loyal Legion of the United States, composed of former Civil War officers. At the time of his death he was the oldest alumnus of Marietta College. While active in social and civic affairs, Dr. Frame's chief interest was in his profession and his professional activities. In addition to his medical affiliations, Dr. Frame was a member of the Piqua Club, the Masonic Lodge and the G. A. R. He is survived by one daughter and one one sister.

George Galley, M.D., Cincinnati; Medical College of Ohio, Cincinnati, 1905; aged 61; died April 10. Dr. Galley had practiced in Cincinnati for the past 27 years. He formerly resided in Sidney where he taught school. Surviving is one son.

Adolph J. Girardot, M.D., Toledo; Detroit College of Medicine and Surgery, 1895; aged 62; former member of the Ohio State Medical Association and the American Medical Association; died

April 15 in the U. S. Veterans' Hospital, Waukegan, Illinois, of a lung infection caused by poison gas. Dr. Girardot was gassed during the World War while in command of a sanitary detachment of the 37th Division. Born in Canada, Dr. Girardot had spent most of his life in Toledo. He enlisted in the army shortly after the close of the Spanish-American War and after leaving military service maintained an active interest in the Ohio National Guard. He served with the troops on the Mexican border and later went to France with the 37th Division. He held the Croix de Guerre with a gold star. Dr. Girardot was a member of the Knights of Columbus of Columbus and the Catholic Knights of Ohio. Surviving are his widow, three daughters, three sons, two sisters and one brother.

William J. Gorey, M.D., Columbus; College of Medicine, Ohio State University, 1919; aged 38; former member of the Ohio State Medical Association and the American Medical Association; died April 14 following a long illness. Dr. Gorey was a member of the Phi Kappa and Alpha Kappa fraternities, Knights of Columbus and Elk lodges, and the American Legion. He leaves one daughter and one son, his parents and one sister. Mrs. Gorey died of pneumonia three weeks after the death of her husband.

William J. Grimes, M.D., East Liverpool; Starling Medical College, Columbus, 1886; aged 75; former member of the Ohio State Medical Association and the American Medical Association; died March 31 following a stroke of paralysis. Dr. Grimes was born in Barnesville, Ohio, and located in East Liverpool in 1902. He was a member of the Odd Fellow Lodge. Surviving are one daughter, one half-brother, and three half-sisters.

George T. Hannah, M.D., Toledo; Ohio Medical University, Columbus, 1906; aged 52; member of the Ohio State Medical Association and the American Medical Association; died April 16 following an operation. Dr. Hannah was a native of Suffolk, Virginia. He began the practice of medicine in Cygnet, Ohio, and was for several years the only physician on the island of Put-in-Bay. He moved to Toledo about 17 years ago. He was a member of the Sylvania Golf Club and the Elks' Lodge. Besides his widow, Dr. Hannah leaves two daughters, his mother, one brother and one sister.

John A. L. Harris, M.D., Toledo; Starling Medical College, Columbus, 1896; aged 66; died March 30 following a brief illness. Dr. Harris had been a resident of Toledo 19 years. Surviving are his widow, one son, three daughters, two brothers and two sisters.

Charles A. Henry, M.D., Fostoria; Rush Medical College, Chicago, 1901; aged 55; former member of the Ohio State Medical Association and the American Medical Association; died April 6 following a major operation. Dr. Henry was the son of the late Dr. Charles A. Henry. Following his graduation from medical school, he joined his father in active practice in Fostoria. During the World War, Dr. Henry served as a captain in the medical corps. He was a member of the American Legion and the Elks' Lodge. Surviving are his widow and two daughters.

John H. Martin, M.D., New Matamoras; College of Physicians and Surgeons of Baltimore, Baltimore, Md., 1893, aged 71; former member of the Ohio State Medical Association and the American Medical Association; died April 28 of heart trouble. Dr. Martin was a native of Monroe County, moving to New Mataromas in 1861 with his parents. His father practiced medicine there for more than 40 years. Dr. Martin was a member of the Masonic Lodge, Methodist Episcopal Church and the McGuffey Society. Surviving him are his widow, one son, Dr. Francis E. Martin, New Martinsville, West Virginia, one brother and three sisters.

Edward F. Menger, Jr., M.D., Marietta; Medico-Chirurgical College of Philadelphia, 1909; aged 50; died April 23. Dr. Menger was for almost 20 years connected with the Department of Interior in work among the Indians, being in charge of the medical departments of some of the large Indian schools. He was a member of the Masonic Lodge. Surviving are his widow, his mother, and two sisters.

Frank S. Pomeroy, M.D., Chardon; University of Wooster Medical Department, Cleveland, 1881; aged 76; member of the Ohio State Medical Association and the American Medical Association; died April 12 of pneumonia following a cerebral hemorrhage. Dr. Pomeroy had been engaged in active general practice for more than 50 years. A former coroner of Geauga County, Dr. Pomeroy was born in Huntsburg, Ohio, on Christmas Day, 1855. He read medicine with his uncle, Dr. Orange Pomeroy and started in active practice in Montville on February 14, 1879, attending the University of Wooster Medical Department, Cleveland, during the winter. He was graduated from medical school in 1881, being one of the oldest alumni of what is now Western Reserve University and was one of the oldest members of the Ohio State Medical Association, his membership dating from 1882. Dr. Pomeroy was the last surviving charter member of the Geauga County Medical Society as it was reorganized in 1881. He served his society as a delegate to State Association meetings for many years and had many friends throughout the state. In 1884 and 1885, Dr. Pomeroy took post-graduate and special work at the University of New York City, receiving his degree from that university in 1885. In 1886, he moved to Chardon. On February 14, 1929, the Chardon Kiwanis Club and the Geauga County Medical Society, with many citizens of the com-

munity, celebrated his 50th anniversary in the practice of medicine by tendering him an "Honor Party". Besides his widow, Dr. Pomeroy is survived by two sons, Dr. Orange B. Pomeroy, Cleveland, and Clyde Pomeroy, Chardon, and three sisters. The funeral services held in the Congregational Church were largely attended, and many members of the medical profession from Northeastern Ohio attended.

Clarkson R. Schooley, M.D., Barnesville; Starling Medical College, Columbus, 1891; aged 62; died April 26 of heart trouble. Dr. Schooley was the son of the late Dr. and Mrs. Addison Schooley of Somerset. Because of his health Dr. Schooley gave up active practice a number of years ago and for a time traveled for a wholesale drug house and engaged in newspaper work. Surviving are his widow, one son, two brothers and one sister.

Oscar W. Stark, M.D., Cincinnati; Columbia University College of Physicians and Surgeons, 1887; aged 67; died April 19 following a heart attack. Dr. Stark had practiced in Cincinnati since his graduation from medical college. He was a member of the Masonic Lodge. Surviving are his widow and one daughter.

Samuel A. Stout, M.D., Montgomery County; Hospital Medical College, Louisville, 1900; aged 64; died April 26 as a result of an automobile accident near Dayton. He had practiced in Montgomery County since graduation from medical school. Surviving are his widow, one daughter and two brothers.

Charles W. Tidball, M.D., Norwood; Eclectic Medical College, Cincinnati, 1879; aged 75; died May 6 following a stroke of paralysis. Dr. Tidball retired two years ago after 40 years of active practice. For many years he was physician at the Hamilton County Infirmary and former health officer of Norwood. Dr. Tidball was the son of Valentine C. Tidball, pioneer Cincinnatian and publisher of the old *Eclectic Medical Journal*. He leaves two sons, two brothers and one sister.

Charles D. Treister, M.D., Cleveland; Cleveland College of Physicians and Surgeons, 1912; aged 42; died March 28 following a brief illness. During the World War, Dr. Treister was a captain in the medical corps and saw overseas service. Besides his widow, he leaves one son.

Charles G. Van Tilburg, M.D., Hayesville; Cleveland Medical College, 1898; aged 66; died April 20. Dr. Van Tilburg was a member of the town council, the county board of health and the Methodist Episcopal Church. He had practiced in Hayesville for 39 years. Surviving are his widow, three daughters, one sister and one brother.

Owen C. Vermilya, M.D., Fremont; Eclectic Medical College, Cincinnati, 1887; aged 68; member of the Ohio State Medical Association and a fellow of the American Medical Association; died April 3 of pneumonia. Dr. Vermilya was a native of Savannah, Ashland County. He taught school until he entered Ohio Wesleyan University where he studied for two years before entering medical school. Soon after graduation, he entered the practice of medicine in Fremont in partnership with the late Dr. J. D. Bemis. Dr. Vermilya was at one time president of the board of education and served as city health commissioner from 1902 to 1908. He was a past president of the Sandusky County Medical Society and one of its most active members. He was a member of the Port Clinton Yacht Club, the Masonic Lodge and the Methodist Episcopal Church. Dr. Vermilya was an ardent supporter of amateur athletics and an athlete of prominence. Surviving are his widow, one daughter, his mother, four brothers, one of whom is Dr. E. L. Vermilya, Fremont, and one sister.

KNOWN IN OHIO

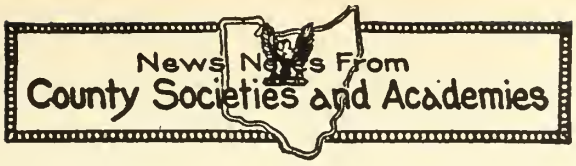
Robert W. Cooke, M.D., Van Nuy, California; College of Medicine, University of Cincinnati, 1924; aged 36; died March 26 following an extended illness. Dr. Cook spent his boyhood days in Bellefontaine, moving to California after his graduation from medical school. He was a World War veteran. In addition to his widow, he leaves his mother, two sisters and one brother, Dr. Kenneth Cooke, Cincinnati.

Edgar M. Hatton, M.D., Orlando, Florida; Starling Medical College, 1892; aged 81; former member of the Ohio State Medical Association; died March 20 of Bright's disease. Dr. Hatton moved to Orlando six years ago following his retirement from active practice of 32 years in Columbus. Surviving are his widow, two brothers, and a sister.

George J. Walsh, M.D., Albuquerque, New Mexico; College of Medicine, Ohio State University, 1912; aged 42; former member of the Ohio State Medical Association; died March 29; Dr. Walsh was a former resident of Columbus. He leaves five sisters.

Clarence J. Williamson, M.D., Dayton, Kentucky; Eclectic Medical College, Cincinnati, 1928; aged 42; died March 7 of pneumonia. Dr. Williamson formerly resided in Massillon. He leaves one sister.

Interesting data on hospital building expenditures during 1931 and the first quarter of 1932 is found in a recent issue of the *Architectural Record*. The total sum spent for hospitals during 1931 was $117,001,900. It was estimated that during the first three months of this year approximately $20,000,000 has been expended in 37 states east of the Rocky Mountains.



First District

ACADEMY OF MEDICINE OF CINCINNATI

(H. H. Shook, M.D., Secretary)

May 2—Union Central Building. Program: "Spontaneous Rupture of Large Ovarian Cyst", Dr. J. D. Heiman; "A Case of Bicornate Uterus", Dr. Louis Feid, Jr.; "A Case of Dextrocardia", Dr. Clifford J. Straehley; "A Case of Self Traumatization", Dr. J. W. McCammon; "Sublingual Fibroma, Bede Disease", Dr. D. J. Bradley.

May 9—Union Central Building. Program: "Chemical Changes in the Blood in High Intestinal Obstruction", Dr. George M. Guest and Dr. William DeWitt; "A Final Report on the Treatment of Tularemia with a Specific Antiserum", Dr. Lee Foshay.

May 16—Union Central Building. Program: "Hereditary Factors in Vascular Disease", Dr. H. B. Weiss; "A Newer Method in the Treatment of Chancroid", Dr. H. L. Claassen.

Adams County Medical Society held its regular meeting April 20 at Maysville, Kentucky, with Dr. D. C. Houser, president of the Ohio State Medical Association, as the guest of honor. Following a brief meeting at the office of Dr. A. R. Carrigan, those in attendance went to the Hayswood Hospital where a program of clinics was presented. Following a luncheon for members and their wives at the Central Hotel, the following program was presented: "Conjunctivitis", Dr. J. M. Brooke, Peebles; "Encephalitis Lethargica, with report of a case", Dr. O. E. McHenry, Blue Creek; "Acidosis", Dr. J. C. Littell, Manchester. Dr. and Mrs. Carrigan entertained the society and guests at dinner.—O. T. Sproull, M.D., Secretary.

Butler County Medical Society at its regular meeting April 28 at Mercy Hospital, Hamilton, adopted a resolution opposing present legislative restrictions on the prescribing of medicinal liquor. Plans were made for the next meeting of the society in June when a golf tournament and banquet will be held at the Butler County Country Club.—News Clipping.

Clermont County Medical Society met in the school auditorium, Owensville, on April 20. Following the business session, Dr. Eslie Asbury, Cincinnati, presented a paper on "Modern Methods of Fracture Treatment" and Dr. C. E. Wooding, Cincinnati, read one on "Management of Different Stages of Pulmonary Tuberculosis".—Allan B. Rapp, M.D., Secretary.

Clinton County Medical Society at its regular meeting April 5 at the Shreve Hotel, Wilmington, heard two interesting papers on the general subject of immunization. Dr. Kelley Hale spoke on "Define and Discuss Bacteriophage?" and Dr. Robert Conard talked on "Hypersusceptibility, Hypersensitivity and Anaphylaxis".—News Clipping.

Second District

Clark County Medical Society met in regular session April 13 at the Hotel Bancroft. Dr. Clement Jones, Springfield, was the principal speaker, talking on "Electrocardiology". He stressed the point that the electrocardiographic method is limited to information relative to the conductivity of the innervation and that but small information regarding valvular conditions can be elicited by this method. The presentation showed the results of careful preparation and was well received.

At the regular meeting on April 27, Dr. Cameron Haight, University of Michigan Medical School, addressed the society on "The Widening Scope of Thoracic Surgery". He covered the subject of chest surgery in a complete and intelligent manner and stressed the importance of surgical intervention in pulmonary conditions, especially in chest conditions having to do with tuberculosis. Dr. Haight urged the use of this method in cases where results had not been obtained by routine methods within a reasonable time.

Following the address, the society voted an honorary life membership to Dr. L. L. Syman, Springfield, who after 32 years of active practice has retired because of ill health.—E. C. Nehls, M.D., Secretary.

Darke County Medical Society at its regular meeting April 8 at the Service Restaurant, Greenville, was addressed by Dr. Milton B. Cohen, Cleveland, on "Recent Contributions of Allergy to the Diagnosis and Treatment of Some Common Skin Conditions".—News Clipping.

Greene County Medical Society met in Xenia on May 5. Following the presentation of several case reports, Dr. P. B. Wingfield, Yellow Springs, addressed the society on "Review of Recent Literature on Nephritis". A general discussion followed.—H. C. Schick, M.D., Secretary.

Miami County Medical Society held a chicken dinner meeting May 13 at the Coates' Inn, West Milton. A paper on "Traumatic Surgery From the Standpoint of the General Practitioner" was read by Dr. H. R. Pearson. Dr. M. I. Miller pre-

sented one on "Present Status of Treatment of Vomiting and Toxemias of Pregnancy".—Bulletin.

Montgomery County Medical Society met in regular session May 6 in the auditorium of the Fidelity Medical Building. The guest speaker was Dr. James M. Pierce, Cincinnati, formerly assistant professor of obstetrics and gynecology, University of Michigan, who discussed "The Hygiene of Pregnancy".—Bulletin.

Preble County Medical Society at its meeting April 21 at the Seven Mile Tavern, Eaton, was addressed by Dr. Robert C. Austin, Dayton. Dr. Austin spoke on "Differential Diagnoses of the Acute Abdomen".—News Clipping.

Third District

Allen County—The Academy of Medicine of Lima and Allen County was addressed on April 21 by Dr. J. H. J. Upham, Columbus, dean of the College of Medicine, Ohio State University. Dr. Upham spoke on "Heart Disease of Middle and Past-Middle Life".—News Clipping.

Auglaize County Medical Society at its regular meeting on April 14 at St. Mary's was entertained by a symposium on arthritis presented by eight members of the Academy of Medicine of Lima and Allen County, namely: Drs. G. E. Jones, W. W. Beauchamp, F. G. Maurer, G. E. Miller, E. H. Hedges, R. O. Ruch, Burt Hibbard and E. B. Pedlow.—News Clipping.

Hancock County Medical Society held its regular meeting April 6 at the Elks' Home, Findlay. Following the business session Dr. T. L. Ramsey, Toledo, presented an interesting illustrated paper on "Pathological Conditions of the Testicle".—H. O. Crosby, M.D., Secretary.

Logan County Medical Society was addressed by Dr. Kennon Dunham, Cincinnati, at a dinner meeting for members and their wives on April 14 at the Hotel Logan, Bellefontaine. Dr. Dunham discussed many phases of tuberculosis.

At the regular meeting of the society on May 6, Dr. W. N. Wishard, Indianapolis, was the principal essayist, presenting three papers on the treatment of prostatic ailments.—News Clipping.

Marion County Academy of Medicine met in regular session April 5 at the City Hospital, Marion. Dr. Fillmore Young spoke on "Recent Advances in Modern Medicine", lauding American physicians and scientists for taking the lead in the advancement of medical science. Dr. N. Sifritt, county health commissioner, addressed the society on "Undulant Fever". At a short business session, Dr. F. L. Thomas was elected a trustee for a term of four years and Dr. J. W. McMurray a trustee for a term of three years. A committee consisting of Drs. J. W. McMurray, J. W. Jolley, Willard Bull, Bernard Taylor and L. L. Roebuck was appointed to confer with the city and county nursing services. The society voted to cooperate with the county health commissioner in a preschool examination program.—News Clipping.

Fourth District

ACADEMY OF MEDICINE OF TOLEDO AND LUCAS COUNTY

(A. P. Hancuff, M.D., Secretary)

April 29—Eye, Ear, Nose and Throat Section. Academy Building. Program: "The Ear from a Pediatrician's Viewpoint", Dr. D. C. Mebane; "Electrocoagulation of Tonsils", Dr. W. W. Alderdye; "Pituitary Tumor, Case Report", Dr. R. E. Boice; "Optic Neuritis, Case Report", Dr. M. D. Bourne; "A Localized Bronchictasis", Dr. G. F. Denyes; "Lateral Sinus Thombosis, Case Report", Dr. L. R. Effler; "Hemangioma in Naso Pharynx, Case Report", Dr. W. W. Randolph; "Optic Neuritis, Case Report", Dr. J. L. Roberts.

May 6—General Session. Academy Building Program: "Is the Cost of Medical Care Too High for the Average Man?" affirmative, Dr. E. W. Huffer; negative, Dr. Frank C. Clifford; affirmative discussants, Dr. J. A. Muenzer, Dr. J. Lester Kobacker, Dr. W. B. Sloan, Dr. K. C. McCarthy, Dr. W. A. Neill; negative discussants, Dr. J. T. Murphy, Dr. L. E. Payne, Dr. L. A. Levison, Dr. J. V. Pilliod and Dr. E. J. McCormick. Buffet supper.

May 13—Section on Pathology, Experimental Medicine and Bacteriology. Academy Building. Program: "Symposium on Tuberculosis". Papers: "Evaluation of Sedimentation Test in Lung Infections", Dr. Howard Holmes; "Tuberculin Testing of Children—Technique and Accuracy", Dr. Hugh M. Foster; "Tuberculosis of the Skin—Presentation of a Case", Dr. Edward Binzer.

May 20—Medical Section. Academy Building. Program: "Treatise on Syphilis", Dr. Loren W. Shaffer, Detroit.

May 27—Surgical Section. Academy Building. Program: "Diseases of Biliary Tract—Medical and Surgical Aspects", Dr. C. D. Brooks, associate surgeon, Harper Hospital, Detroit.

Putnam County Medical Society held its regular meeting April 5 at the Hotel DuMont, Ottawa. Dr. Norris W. Gillette, Toledo, addressed the society on "Diagnosis of Goiter and Its Treatment".—News Clipping.

Sandusky County Medical Society held its regular meeting April 28 at Fremont. The principal address of the evening was made by Erving V. Burns, Findlay, D.D.S., vice president of the Ohio State Dental Association, on "Oral Infection and Its Relation to Degenerative Diseases". Members of the Sandusky County Dental Society were guests of the medical society.—News Clipping.

Wood County Medical Society met in regular session at the Woman's Club, Bowling Green, on April 21. After dinner, the following program was presented and discussed: "Ambulatory Treatment of Hemorrhoids", Dr. L. J. Herold, Toledo; "Common Middle Ear Infections and Their Complications", Dr. L. R. Effler, Toledo, and "Some of the Complications Met With in Appendicitis", Dr. Thomas F. Heatley, Toledo.—R. N. Whitehead, M.D., Correspondent.

Fifth District

ACADEMY OF MEDICINE OF CLEVELAND

(Clarence H. Heyman, M.D., Secretary)

May 6—Clinical and Pathological Section. St. John's Hospital. Program: "A New Mechanical Method of Hip and Leg Extension (Jones' Method)—Demonstration of Case", Dr. Walter G. Stern; "Presentation of Two Cases of Extensive Scar and Contractures Following Trauma and Burn", Dr. J. R. Ripton; Multiple Cartilaginous Exotoses and Fragilitas Ossium", Dr. G. I. Bauman; "Carcinoma of Male Breast", Dr. R. J. Schraff; "Carcinoma of Larynx and Mastoditis of Lateral Sinus Thrombosis", Dr. J. T. Collins; "Peritonitis, Complicating Appendicitis", Dr. F. T. Gallagher; "Review of Some Advances In Diagnostic Apparatuses Since 1900", Dr. R. K. Updegraff; "Case of Lipoid and Glomerular Nephritis", Dr. H. Sneiderman.

May 11—Obstetrical and Gynecological Section. Herrick Room. Program: "Maternal Mortality", Dr. Theodore Miller; "A Case of Ruptured Ovarian Cyst in the Newborn", Dr. S. Dodek; "Hemorrhage of the Newborn", Dr. Leon H. Dembo.

May 13—Joint meeting of Experimental Medicine Section and the Cleveland Society for Experimental Biology and Medicine. Institute of Pathology. Program: "Dosimetry in Roentgen and Radium Therapy", Otto Glasser, Ph.D.; "Considerations on the Creatinine and Urea Excretion Ratios", Dr. R. Dominguez and Elizabeth Pomerene, Ph.D.; "Changes in the Circulation Following Birth", Bradley M. Patten, Ph.D.; "Studies on Adrenal Insufficiency—Experimental and Clinical", Dr. J. M. Rogoff.

May 20—General Session. Auditorium. Program: "Radiant Energy—Its Use in General Practice", Dr. Henry J. Gerstenberger; "Science and Art in Child Nourishment", Dr. C. A. Aldrich, assistant attending physician, Children's Memorial Hospital, Chicago; Informal remarks by Dr. Elliott C. Cutler.

Ashtabula County Medical Society held its regular meeting at the Hotel Ashtabula, Ashtabula, on April 12. Following dinner, Dr. C. L. Cummer, Cleveland, councilor of the Fifth District, addressed the society on "Dermatitis Due to External Irritants". An informal discussion concluded the program. At the regular meeting of the society on May 10, Dr. Harry R. Trattner, Cleveland, was the guest speaker. He spoke on "Prostatectomy" and the paper was illustrated by motion pictures showing the perineal method of approach—E. H. Merrell, M.D., Secretary.

Geauga County Medical Society at its regular meeting April 27 adopted a resolution endorsing the work of the county health department and opposing a move to abolish the department as an "economy measure". A committee consisting of Dr. Lucy Stone Hertzog and Dr. G. R. French was appointed to prepare a resolution in memory of the late Dr. Franklin S. Pomeroy, dean of Geauga County physicians. The following resolution has been drafted by the committee and will be acted upon by the society at an early meeting:

"Dr. Pomeroy had the distinction of being one of the oldest alumni of Western Reserve University, and was also one of the oldest members of the Ohio State Medical Association. He was the last surviving charter member of the Geauga County Medical Society, as it was re-organized in 1881.

"Dr. Pomeroy served this Society many times as president and in every other capacity of helpfulness with honor, dignity and zeal.

"In association with his colleagues, he was always honorable, ethical and trustworthy—a splendid gentleman.

"By his death the Western Reserve has lost one of the few remaining pioneers, who, under amazing handicaps and difficulties practiced medicine in the saddle-bag era.

"We shall miss his clear and forceful contributions to our meetings, his experience and his leadership. We have been proud to be associated with him and we shall cherish his memory.

"In the richness of a medical experience of over fifty years, he gave succor, hope and life to thousands who gratefully remember him in this community.

"Turning aside from his value to humanity, our Society desires to extend its heartfelt sympathy to his family in this time of loss and grief.

"Be it resolved that we place the above upon our minutes as the final record and tribute to a loyal member; that the secretary be directed to send a copy to his faithful wife and to their sons, and that a copy be forwarded to the *Ohio State Medical Journal* for publication.

" 'The day has come, not gone;
The sun has risen, not set;
Thy life is now beyond
The search of death to change
Not ended, but begun
O noble soul! O gentle heart;
Hail and farewell.' "

—Isa Teed-Crampton, M.D., Secretary.

Lorain County Medical Society at its regular meeting April 12 at the Elyria Memorial Hospital was addressed by Dr. H. C. King, Lakewood, on "Diagnosis and Treatment of Gastric Ulcer". The address was augmented with *X*-ray pictures shown by Dr. J. R. McDowell, Lakewood, and a member of the staff at the Elyria Memorial Hospital. A general discussion closed the program.—W. E. Hart, M.D., Secretary.

Sixth District

Ashland County Medical Society held its regular monthly meeting April 8 at the Samaritan Hospital, Ashland. Dr. Norris Gillette, Toledo, gave an interesting illustrated lecture on "Goiter". He also exhibited motion pictures depicting the anatomy of structures about the thyroid gland and of the technique he used in thy-

roidectomy. Dr. A. H. Schade, Toledo pathologist, discussed the pathological aspects of thyroid diseases, drawing a parallel in certain cases where the clinical symptoms were constant with a certain definite pathological picture. Dr. C. B. Meuser reported a fatal case of bulbopontine poliomyelitis which was accompanied by complete paralysis of the whole body. He stressed the necessity of spinal puncture at an early stage.—Paul E. Kellogg, M.D., Secretary.

Mahoning County Medical Society held its Sixth Annual Post Graduate Day on April 28 at the Hotel Ohio, Youngstown. An all-day session was held, the program being presented by a group from the staff of the Peter Bent Brigham Hospital, Boston, namely: Dr. Henry A. Christian, Dr. Samuel A. Levine, Dr. William C. Quinby and Dr. Merril C. Sosman. There was a record-breaking attendance of 425 registrants, many physicians from Pittsburgh and Cleveland attending.

On May 19, Dr. Temple Fay, professor of neurological surgery, Temple University School of Medicine, Philadelphia, addressed the society on "Intracranial Pressure Problems Encountered in General Medicine".

It was announced that at the June 21 meeting of the society, Dr. C. D. Christie, clinical professor of medicine, Western Reserve University, will speak.—J. Rosenfeld, M.D., Correspondent.

Portage County Medical Society held its regular meeting May 5 at the newly completed Robinson Memorial Hospital, Ravenna. The principal address was made by Dr. J. M. Waugh, Cleveland, on "Diseases of the Oesophagus" with lantern slides. A resolution expressing sorrow at the death of Dr. D. W. Stevenson, Akron, former councilor of the Sixth District, was adopted.

At the April meeting of the society, held on April 7, at the office of Dr. S. A. Brown, Kent, a case report on "Tetany" was presented by Dr. J. R. Turner, Kent, and a paper on "Differential Diagnosis of Diseases of the Chest" was read by Dr. Theodore Herwig, Akron.—E. J. Widdecombe, M.D., Secretary.

Stark County Medical Society at its meeting April 12 at the Elks' Club, Canton, was addressed by Dr. Andre Crotti, Columbus, on "Research on the Etiology of Goiter".—Bulletin.

Summit County Medical Society met in regular session May 10 at the Akron City Club. The society was addressed by Dr. Jonathan Forman, Columbus, on "The Atophy (or Specific Inherited Hypersensibility in the Human) in General Practice".

The society adopted the following resolution in memory of Dr. D. W. Stevenson, former president of the society and former Councilor of the Sixth District:

WHEREAS, By the death of the late David William Stevenson the Summit County Medical Society and the Medical Profession of the State of Ohio have suffered the loss of a highly respected and valued public spirited citizen, and

WHEREAS, He has given valuable service to our profession and the entire community by his service in the interest of organized medicine, both State and National, through his service as President of this Society and as Councilor of the Sixth District of Ohio.

Therefore be it resolved that we, members of the Summit County Medical Society acknowledge the loss of this influential member of our Profession. And we extend our sincere sympathy to the members of his immediate family.

A copy of this resolution to be placed on file and copies be sent to the bereaved family and the Ohio State Medical Association.

Seventh District

Belmont County Medical Society held its regular meeting April 7 at the Kilkenny Inn, St. Clairsville. The principal address of the evening was made by Dr. C. C. Mechling, Pittsburgh, on "Diagnosis and Treatment of Acute Anorectal Diseases", with motion pictures. A general discussion followed.—F. R. Dew, M.D., Correspondent.

Columbiana County Medical Society at its meeting on May 10, Lisbon, was addressed by Dr. C. H. Bailey on "Parotitis" with case histories.

At a meeting of the society on April 14 at the office of Dr. F. A. Bennett, Lisbon, Dr. P. C. Hartford, East Palestine, presented a report on two recovered cases of Perthe's disease and discussed the differential diagnosis with tuberculosis of the hip. Dr. Stanton Heck, Salem, opened the discussion with some sidelights on tuberculosis metastasis.—T. T. Church, M.D., Secretary.

Jefferson County Medical Society had as its guest speaker at its meeting on April 26, Steubenville, Dr. C. C. Mechling, Pittsburgh.

At a meeting of the society on April 19, the society was addressed by Dr. W. M. Garrison, superintendent of the Belmont County Sanitorium.—News Clipping.

Tuscarawas County Medical Society met in regular session April 14 at the New Philadelphia Chamber of Commerce. Dr. D. H. Downey read a paper on "Skull Fractures". It was discussed by Dr. Coleman and Dr. Shumaker.—Bulletin.

Tuscarawas County Medical Society held its regular meeting May 12 at Dover with Dr. Lichtbleu, Canton, and Dr. Max Shaweker, Dover, as speakers. They presented a case report and discussion of "Agranulcocytic Angina".—Bulletin.

Eighth District

Fairfield County Medical Society at its regular meeting April 12 at the Florentine Restaurant, Lancaster, was addressed by Dr. V. A. Dodd, Columbus.—News Clipping.

Guernsey County Medical Society met in regular session April 7 at the Romance Restaurant,

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Cincinnati—The University of Cincinnati Chapter of Sigma Xi presented Dr. Arthur I. Kendall, professor of research in bacteriology, Northwestern University, in a public lecture on the subject, "Filterability of Bacteria and Its Relationship to Biology and Medicine".

Toledo—Dr. Henry L. Wenner, Jr., has accepted a position as surgeon-in-chief of the Pelton Clinic, Elgin, Illinois.

Miamisburg—Dr. C. C. Borden addressed the local Rotary Club on the subject, "Cancer".

Kenton—Dr. C. L. Johnson, formerly of Fremont, has opened offices here.

Cleveland—Dr. Paul V. Duffy has been appointed official physician for the Cleveland Boxing Commission.

St. Marys—"The Latest Things in Medicine and Surgery" was the subject of a talk given by Dr. Guy E. Noble before the St. Paul's Men's Association.

Portsmouth—Dr. J. P. McAfee has been named city physician, succeeding Dr. William Scaggs, resigned.

Sandusky—Dr. William Burger, formerly of Cleveland, has moved to Sandusky and will be associated with Dr. P. F. Southwick.

Cleveland—A brochure of 14 sketches of pioneer physicians of the Northwest Territory, published originally in the *Bulletin* of the Cleveland Academy, is being sold by the Academy.

Lima—The Triologic Society of Lima had as its guest speakers at a recent dinner meeting Drs. J. H. J. Upham, Hugh Beatty and Albert D. Frost of Columbus.

Cleveland—Dr. C. H. Heyman has been reelected president of the Heidelberg College Club of Cleveland.

Cleveland—Dr. Marion Douglass presided and Dr. L. R. Brigman was a speaker at a recent reunion of the Cleveland alumni of Kenyon College.

Cleveland—Officers of the newly formed Cleveland Neurological Society are: Dr. S. Baumoel, chairman, and Dr. W. James Gardner, secretary.

Cleveland—Dr. Charles Higgins was a recent speaker before the Wayne County Medical Society, Detroit.

Cleveland—Dr. J. W. Epstein gave a lecture on "The Common Cold" at the Ansel Road Temple under the auspices of the Cleveland Council of Jewish Women.

Cleveland—Dr. C. S. Beck recently addressed the Johns Hopkins Medical Society, Baltimore, on "Pneumocardiac Temponade and Its Relation to the Surgery of the Chest".

Cincinnati—The following changes in the medical faculty at the University of Cincinnati have been announced: Dr. Stanley E. Dorst, associate professor of medicine, to be chief clinician of the medical clinic in the Out-Patient Dispensary; Drs. Hiram B. Weiss and C. A. Mills to be chief clinicians in the Out-Patient Dispensary; Dr. Robert F. Hiestand, promoted from assistant to instructor in medicine; Drs. R. W. Staley, E. O. Swartz and Henry B. Freiberg promoted from instructors to assistant professors in the Department of Urology; Dr. Parke G. Smith promoted to instructor in urology.

East Liverpool—Dr. M. C. Tarr, Wellsville, and Dr. W. N. Gilmore, East Liverpool, were the honored guests at a testimonial dinner given by the medical staff of the East Liverpool City Hospital, in recognition of their half a century of service in the practice of medicine.

Niles—The Niles Kiwanis Club was addressed recently by Dr. Edgar P. Adams, superintendent of the Trumbull County Tuberculosis Hospital.

East Liverpool—Dr. Claude B. Norris, Youngstown, addressed the local Rotary Club recently on the subject of "Cancer".

Bryan—Dr. B. C. Bly, formerly of Montpelier, has purchased the office equipment of the late Dr. M. V. Replogle and has opened offices here in the Replogle residence which he has purchased.

Barberton—Dr. H. L. Smallman has returned from New York City where he took post-graduate work at the New York Post-Graduate School and Hospital.

Springfield—Dr. Clarence W. Hullinger has been appointed city poor physician.

Dayton—Dr. W. Richard Hochwalt has returned to Dayton after two years post-graduate work in orthopedic surgery at the Massachusetts General Hospital and the Children's Hospital, Boston. He is associated with Dr. J. A. Judy.

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Location Wanted—Interested in General Practice, preferably Northwestern Ohio—1,500 to 3,000 population. Address Y. care *Ohio State Medical Journal.*

HOSPITAL NOTES

—At the regular staff meeting of the Detwiler Hospital, Wauseon, the following program was presented: "Chronic Monoxide Poisoning", Dr. J. F. Fry, Ridgeville Corners, and "Acute Dilatation of the stomach With *X*-ray Findings and Intususception in An Infant With Surgical and *X*-ray Findings", Dr. W. P. Evers, Wauseon. Twenty-two members of the staff attended.

—The management of Mercy Hospital, Tiffin, gave a dinner recently honoring Dr. Henry L. Wenner who recently completed 50 years of active practice. Dr. E. H. Porter presided as toastmaster.

—Members of the medical staff and the nurses of Bethesda Hospital, Cincinnati, held a memorial service recently in memory of Dr. Christian Golden, founder of the hospital.

—Dr. H. H. Herman has retired from the active surgical staff of Miami Valley Hospital, Dayton, after 30 years of service, becoming a member of the senior surgical consultant staff of the hospital.

—Dr. C. D. Kurtz, New Philadelphia, has been elected president of the staff of Union Hospital. Dr. D. H. Downey, Dover, was named vice president and Dr. George L. Sackett was re-elected secretary-treasurer.

—The new medical library of the Piqua Memorial Hospital was formally opened at the annual meeting and dinner of the staff. Dr. R. D. Spencer and Dr. J. R. Caywood were named librarians.

—Dr. Charles Lukens was re-elected chief of staff of Flower Hospital, Toledo, at the annual meeting of the staff. Dr. B. H. Carroll was re-elected vice chief. Dr. Lewis R. Carr was named secretary-treasurer; Dr. H. F. Howe, director of medicine and Dr. E. W. Doherty, director of surgery.

—Mrs. Christian R. Holmes has presented Holmes Memorial Hospital, Cincinnati, with $3,000 to be used for the purchase of an ophthalmic unit.

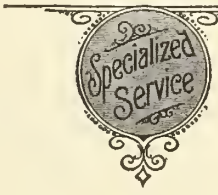
—Members of the staff and the management of St. Francis Hospital, Cincinnati, gave a luncheon honoring Dr. Raymond E. Gaston and Dr. David E. Weaver who have served on the staff for 25 years.

—Dr. William A. Klann, formerly of Cincinnati, has joined the staff of the Pool Hospital, Port Clinton.

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Northern Tri-State Meeting Held in Toledo, April 12

Fifty-ninth annual meeting of the Northern Tri-State Medical Association was held in the Academy of Medicine Building, Toledo, on April 12, with approximately 300 in attendance.

The morning session was given over to clinics. Dr. Ora O. Fordyce and Dr. N. W. Kaiser of the Toledo State Hospital gave a psychiatric clinic. They demonstrated the various types of insanity showing about thirty patients.

Dr. Edward P. Gillette, Gillette Clinic, Toledo, held an orthopedic clinic. He gave the newer methods of treatment of the various types of fractures and the use of proper appliances, showing many interesting *X*-ray plates of fractures, their treatment and end results. He also gave an interesting report on his results in the making of new joints from Fascia Lata.

Dr. U. J. Wile, Professor of Dermatology, University of Michigan, conducted a skin clinic, showing many patients, making diagnoses, and outlining proper treatment.

The afternoon session was given over to addresses. Dr. Wile, gave a highly scientific presentation of "Fluid Status of Syphilis Therapy" with a suggestion that there is a possibility for better management in the future.

"Papilledema" was discussed in its various phases by Dr. Walter B. Parker, Professor of Ophthalmology, University of Michigan. He presented the former errors of diagnosis and treatment and gave the present interpretation of the subject completely.

Dr. H. B. Lewis, professor of physiologic chemistry, University of Michigan, spoke on "The Recent Studies of Blood Chemistry", advising the discarding the use of many expensive procedures which are of little practical value and conducting the laboratory in the interest of the patient.

Dr. Stanley P. Reimann, Philadelphia, Director of the Research Department of the Lankenau Hospital, gave a practical talk on "Cell Division" making use of the information gained by the laboratory in the use of sulphydryl in treating new growths and chronic ulcerative conditions. He took what appeared to be a dry subject and made it very interesting and practical.

Dr. Warren T. Vaughan, Richmond, Virginia, gave an address on "The Control of Pollen Allergy". He dwelt on the epidemiology of the various varieties of pollen, their seasonal advents, and gave a very comprehensive description of their control. The failures according to Dr. Vaughan, are the results of improper diagnosis and too short a period of treatment. He also laid stress on larger immunizing doses of antigen.

Doctors Max Ballin and Plinn F. Morse, Detroit, illustrated with slides the good results that have been obtained by parathyroidectomies in altered calcium metabolism and its relation to bone conditions.

Dr. Dean Lewis, Professor of Surgery, Johns Hopkins University, illustrated with slides, the lesion of bone and their treatment. He completely discussed and demonstrated bone infections, fractures and tumors.

The following officers were elected for 1933: President, Edward B. Pedlow, M.D., Lima; vice president, G. O. Larson, M.D., Laporte, Ind.; secretary, Edward P. Gillette, M.D., Toledo; treasurer, H. F. Randall, M.D., Flint, Mich.; Counsellors, Chas. Lukens, M.D., Chairman, Toledo; P. N. Sutherland, M.D., Angola, Ind.; J. H. Andries, M.D., Detroit, Michigan.

Dayton—The following Dayton physicians will give physical examinations to candidates for the 1932 Citizens' Military Training Camp at Fort Benjamin Harrison, Dr. V. C. Laughlin, chairman of the campaign for candidates, has announced: Drs. L. E. Brown, H. V. Dutrow, M. D. Prugh, Curtiss Ginn, R. R. Bond, A. J. Choate, T. M. Kirk, and H. A. Slusser.

Pleasant Hill—Dr. Don F. Deeter, a native of Pleasant Hill and recently of Cleveland, has opened offices for general practice here.

AUG 1 1932

The OHIO STATE MEDICAL JOURNAL

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JULY 1, 1932 VOLUME XXVIII Number - - - 7

We must so fortify the intelligence of our community that they may realize that our intelligent cooperation means a lengthening of life, alleviation of pain and the progress of a civilization.—C. W. Waggoner, M.D., in the Toledo Academy of Medicine Bulletin.

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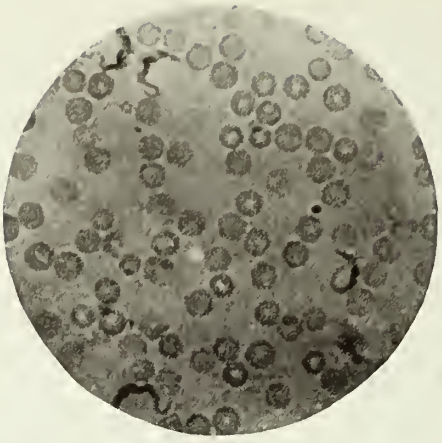
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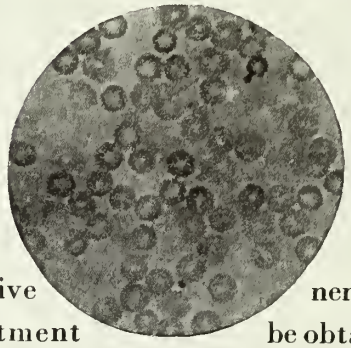
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Ohio State Medical Journal

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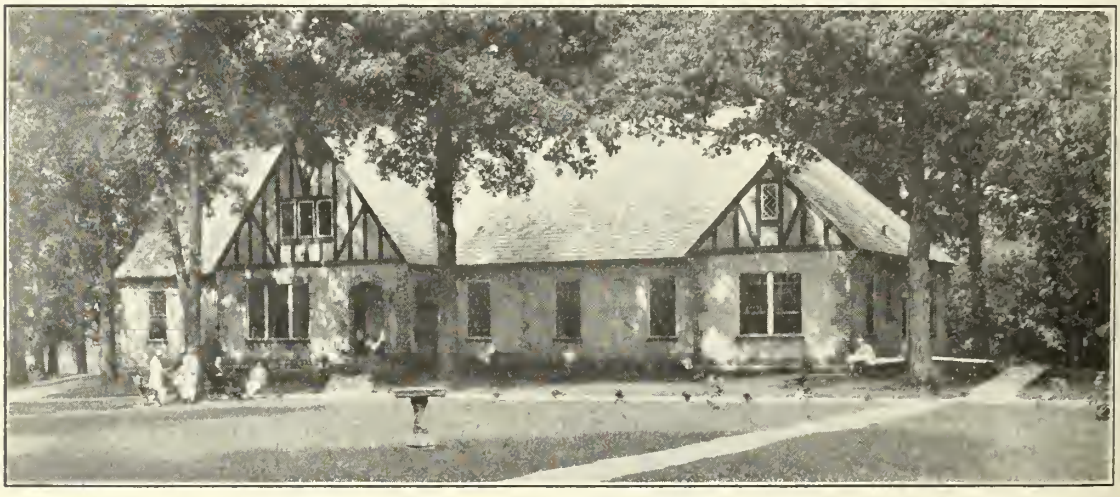
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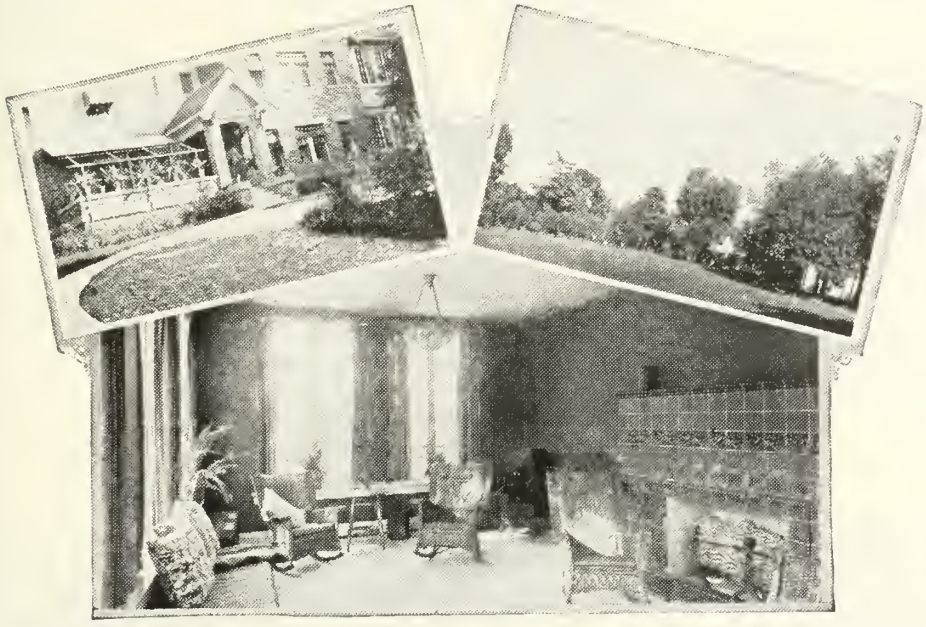
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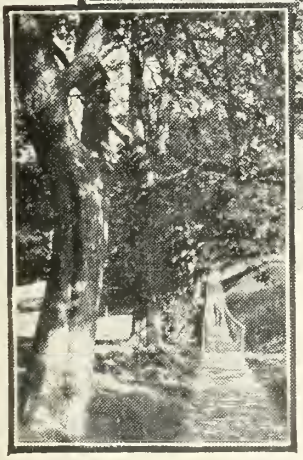
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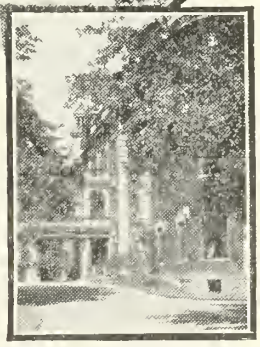
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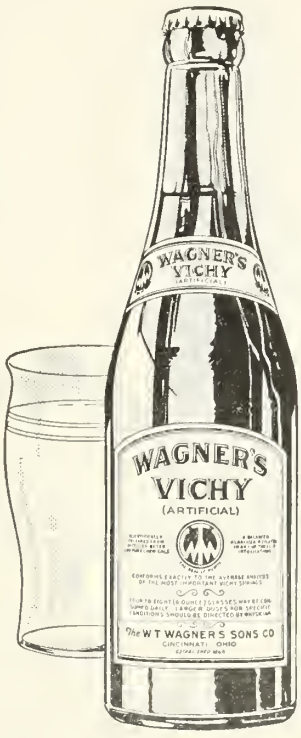
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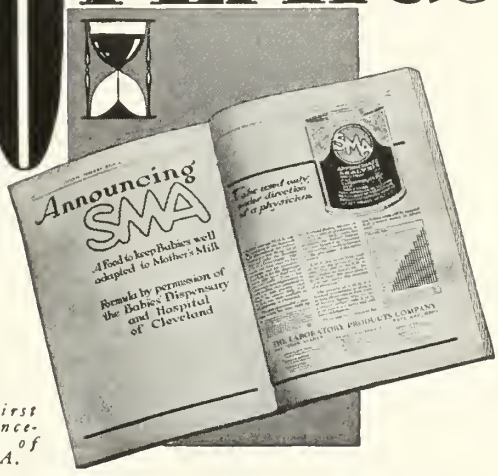
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PUBLIC HEALTH — SOCIAL WELFARE MEDICAL ECONOMICS and ORGANIZATION PROBLEMS

With Editorial Comment by D.K.M.

Shadows of coming events are a warning to medical organization in Ohio against a let-down in organization activities during the summer months, normally periods of suspension of regular meetings.

Physicians' Vital Interest In Public Affairs

There will be no cessation of activity in the machinery of the State Association. Standing and special committees will continue to function on the innumerable serious problems delegated to them. The officers, headquarters, and *The Journal* will constantly be available to requests from the membership, for service and information.

Two future events, especially, illustrate the necessity of constant and united attention of organized medicine—the approaching general election on November 8 when the selection of national, state and local public officials will take place and the next regular session of the Ohio General Assembly, scheduled to open early in January.

Present-day trends demand that medical organization be vitally concerned about, and take an active interest in, governmental, legislative, social and economic questions. The antiquated theory that organized medicine should not bother about civic and public affairs, especially if they be political in nature, has been discarded. Although the medical profession and medical organization, especially, are essentially non-political, it is their responsibility and obligation to take a personal and united interest in public problems in accordance with the fundamentally sound, concerted medical viewpoint on matters affecting public health, medical practice, scientific medicine, and the social-economic status of physicians.

It is the duty of physicians, as individual citizens, to exert every possible effort in support of honest, competent, well qualified and courageous candidates for public offices, national, state or local. The election of office-seekers who are open-minded on health and medical questions and who indicate a willingness to receive and study the information and advice of their physician constituents on medical and health matters, about which the medical profession is the most fully informed, should be encouraged. Bad government and destructive legislation can be reduced to a minimum providing qualified and high-minded candidates are chosen at the polls.

It is highly important that the medical profession, individually and collectively, keep itself accurately informed on the trends in government and legislation and endeavor to form effective contacts with office holders so that the sound policies and principles of medical organization may be explained to and understood by them.

It is especially important at this time that the medical profession take an active interest in the election of members of the forthcoming 90th Ohio General Assembly and formulate plans now for contacting them *before* as well as during the legislative session.

With sudden and radical changes in public sentiment, and with departures imminent in governmental functions, aggravated, no doubt, by the extended economic depression, the next session of the Ohio Legislature will be of unusual importance and seriousness. The flood of social service, subsidy and paternalistic legislation in the present United States Congress indicates the trend toward such legislation in the several states, including Ohio. A bombardment of radical, dangerous, special-privilege and socialistic measures, many of which would have a far-reaching effect on public health, medical practice and scientific medicine, seems certain when the legislature convenes.

The medical profession must be prepared to meet these challenges. Preparation must be made now, before the legislative mill begins to grind and the hectic days at Columbus arrive. Contacts with candidates for the General Assembly before the election and with the successful aspirants after the election should be such that they will look to the spokesmen of the medical profession in each community for advice and guidance on all medical and health legislation.

Activities in these matters are difficult, delicate and sometimes disagreeable, but none the less important and necessary. They must be carried out effectively if the safeguards to public health and the integrity of the medical profession are to be preserved.

Improvements In The Journal

It has frequently been stated by competent newspapermen that the best newspapers, judging them solely from the standpoint of reader-interest and news value, are those which publish in each issue: First, the greatest number of authentic news items, and, second, the greatest number of names of persons figuring in the day's news.

To a large degree, the same criterions may be used to judge the value of practically all publications—for example, publications such as the *Ohio State Medical Journal.*

As pointed out in the recent annual report of the Publication Committee of the State Association (May, 1932, issue of *The Journal)*, every effort is being made to make the *Ohio State Medical Journal* the leader in its particular field. It has made, and is maintaining, an enviable record. However, this does not necessarily mean that it has reached the goal of perfection or that it cannot be of greater service to the members of the State Association.

To progress and to expand its usefulness, *The Journal* must have the cooperation and support of each individual member of the State Association. Especially, must it have the aid and active interest of the officers and correspondents of the county medical societies and academies of medicine, and other committeemen who have been selected by their colleagues as contact men between the county society and the State Association.

Two of the most valuable departments of *The Journal* are those devoted to accounts of the regular meetings of the county societies and academies and to news items pertaining to the professional and civic activities of Ohio physicians.

It is encouraging to note during the past few months the increase in active cooperation and interest of county society and academy secretaries or correspondents in forwarding to *The Journal* accounts of county society or academy meetings and items of general interest to the profession at large.

However, there are some county society secretaries or correspondents who neglect to furnish *The Journal* with news. Naturally, this laxity on their part is reflected both in *The Journal* and by their county medical societies. In some instances, *The Journal* is forced to depend entirely on newspaper accounts of regular county society meetings or special activities of the society. Occasionally these accounts are inaccurate or often they are too brief to be of more than nominal value.

It is to be hoped that every county society and academy of medicine will in the near future have established *direct* news contact with the State Headquarters Office at Columbus, where the material for *The Journal* is assembled, so that *The Journal* will be able to publish as complete an account as possible every month of the activities of the component units and members of the State Association.

Those delegated to assemble news and forward it to *The Journal* should keep in mind that *The Journal* is published on the first day of each month and that material for each issue should reach the State Headquarters Office not later than the 10th day of the month preceding the date of publication.

The Journal is the official publication of the membership of the State Association—it is your *Journal.* It can become of greater service to the membership and become an even bigger and better publication if it has the hearty and active support of the entire membership, and especially correspondents upon whom it can depend for regular accurate and complete reports of medical organization activities in each section of the state.

The Result of Government Extravagance

There is a growing belief that the extravagance of government—federal, state and local—has had much to do with the present depressing state of economic affairs.

There is a feeling among economists and business leaders that economic recovery will not become a complete success until governments execute an about-face and begin in earnest to economize.

Inasmuch as this has become the leading topic of the moment, a series of observations in a recent issue of *Nation's Business* on government spending, taxation and allied subjects is exceptionally interesting and enlightening.

Congressman John McDuffie of Alabama, chairman of the House Special Economy Committee, is lead-off man. Mr. McDuffie tells "Where Uncle Sam Can Save $600,000,000". Quoting from his straightforward enumeration of governmental extravagances:

"The Federal Government is top-heavy, while the powerful hand of Uncle Sam has extended into practically every business, and even into the social life of the citizens. There has been little concern as to whether the expansion involved the duplication of functions already partially performed by the central government or partly or wholly so by the states and municipalities. As a result, expenses of the central government have increased by hundreds of millions of dollars. Federal aid has become something of a narcotic to state and local governments, with the result that individual initiative and local responsibility has been in a measure lulled into inaction and inertia. Peculiarly enough, the expense of local government has not decreased as a result of Federal aid, and many states and cities are hopelessly in debt.

"The tendency to abnormal expansion of government in Washington may be attributed, I think, to three specific causes:

"1. Indifference of taxpayers in the last de-

cade to the increasing costs of the Federal Government.

"2. Activities of the noisy minorities who have been intent upon loading the Federal Government with new activities without regard to whether they involved duplication of service or an unjustified increase in governmental expense.

"3. Willingness of state and local governments to surrender to the Federal Government functions which, under our concepts of government, naturally belong to them. This tendency in such matters as education, development of agriculture, protection of forests, conservation, and a multitude of other things, has thrust upon the Federal Government a multitude of tasks which were never contemplated in the formative days of the republic, and which, even in this advanced day, are often difficult to justify.

"The high-powered propagandist, the bureaucrat and the organized minority are gradually destroying our representative form of government. If the sovereignty of the states means anything at all, it means resistance to the centralization of power in Washington, which has brought the hand of the Federal Government into every phase of business and domestic affairs."

Leafing through the Washington gossip of W. M. Kiplinger, we find these significant paragraphs:

"Here are good questions to ask ourselves:

"1. How much do we want government to do for us? Most of us say we want less, yet we actually demand more.

"2. How much do we get for our money? Most of us say we don't get enough, yet we do not examine closely where the money goes.

"3. How much can we afford from time to time? Most of us were careless about acquiescing in extravagances in good times, and now we are up against the cold necessities of paying in arrears.

"4. How much controversial 'service', as distinguished from noncontroversial 'government,' do we expect from the state? This is a really big point on which organized business should try to agree, or approximately agree."

An illuminating comparison between the plight in which Australia found itself and that which Uncle Sam is combatting is made by T. Ritchie Adam, professor of political science, in an article, "How Spending Put a Country on the Rocks". Australia got to the point where the Government spent half the national income; the spending was unproductive; when the bills came in, Australia couldn't pay, Mr. Adam points out.

"Having given the world an invaluable lesson, the Australians have turned grimly to setting their own house in order," he writes.

"We Can't Save Unless You Help", is the contribution of Louis Ludlow, erstwhile newspaperman and now a member of Congress from Indiana.

Congressman Ludlow declares that the "rising public opinion (against governmental extravagances) must become vocal".

"There will be no improvement until the people order their senators and representatives to stand for economy and to make war on bureaucracy," he said.

"The reform that will save the country—if it is to be saved—will never originate in Congress. It must spring up among the people, and business men and their organizations can be of tremendous influence in the movement."

These writers are not demagogues, but hard-headed thinkers, deeply concerned about a vital problem; endeavoring to present unadulterated facts, and to stimulate serious thought and activity. The return to sanity in government, and eventually to economic equilibrium, may hinge on the success of their appeals and the appeals of others like them.

Practical Instruction to Young Doctors

A plan recently inaugurated by the Educational Committee of the Medical Society of Milwaukee County, Wisconsin, of holding conferences for hospital interns, the purpose of which is to discuss informally some of the practical social and economic problems which confront the young physician just entering practice, suggests similar activities on the part of other medical groups located in centers having hospitals where intern training is given.

Commenting on the activities of the Milwaukee committee along this line, the *Milwaukee Medical Times*, official publication of the society said editorially:

"Unfortunately many young physicians do not realize the importance of some business training until they are out in practice. They are then too busy to give this side of their practice much attention, which often results in deplorable situations. A review of the estates left by physicians is an eloquent reminder of this fact. It is obvious that if all medical schools would include in their curricula a short course in medical economics and simple business methods, this condition in which physicians too often find themselves, would be greatly improved. The Educational Committee has come to the conclusion that it can do something to meet this situation."

Many county medical societies or academies of medicine in Ohio would be in a position to add some such activity to their programs. Ohio has 36 hospitals approved by the American Medical Association for intern training and they are located in 11 different counties. Perhaps activities similar in nature are already being undertaken by some of the 11 county societies or academies. Those which are not might find such a project of considerable benefit to the neophytes in their midst. In fact, by adding to the symposium of subjects discussed, questions of ethics, and professional and public relationships, periodic conferences of this kind undoubtedly would prove popular and beneficial even among physicians already in active practice.

A Warning Across the Sea

Controversies which have arisen in England relative to a proposed scheme for a National Medical Service which would provide blanket coverage for practically the entire population of England offer some interesting observations on and examples of the fallacies of such socialized projects and how quickly they are likely to reach Frankenstein proportions.

Some years ago when the present British "panel system" was proposed and subsequently put into effect, members of the British medical profession offered but feeble protest against this initial socialistic invasion of the prerogatives of the private medical practitioner.

With the passing years, more and more members of the medical profession of England have become panel physicians until now the large majority of the physicians in that country (about 14,600) are working under the provisions of the National Health Insurance Act. Most of those so doing are said to have been entirely satisfied—possibly because of the slight increase in the income of individual physicians through the operation of the government-supervised panel system—until quite recently when political movements sponsoring broad extension of the provisions of the health insurance law were launched.

This jolted the British medical profession into action and, in an effort to forestall the enactment of legislation which would deprive the British physician of what little privileges he now has, the British Medical Association presented its own proposal for revising and modifying to some extent the present health insurance act.

Leaders of the British medical profession have for some time been considerably agitated and anxious regarding what may be the ultimate outcome of the present tendency in England to completely socialize medicine.

According to Dr. W. C. Rappleye, director of study for the Commission on Medical Education, who not so long ago made an extensive tour of most of the European countries, members of the British medical profession are outspokenly dubious regarding the future.

Despite the fact that many of them are not dissatisfied with many of the provisions of the present panel system, they fear that it is but the forerunner of a broader and more extensive program of socialized medicine, similar to the systems now operating in Germany, Austria and several other countries across the channel, he says.

"What the British medical profession fears," Dr. Rappleye declares, "is that a system of medical socialism similar to the kind that has lowered the prestige and standards of medical education in Germany and Austria and has made the practice of medicine in those countries almost a racket will be forced upon the profession in England."

In other words, British physicians are beginning to see the handwriting on the wall. Whether they will be able to successfully combat the further extension of socialized medicine is a matter of conjecture. The passive attitude they have displayed toward socialistic tendencies in the past may act as a bomerang in the present crisis.

Physicians in the United States dare not consider the plight of their European colleagues none of their concern. What has happened in Germany, Austria and Russia, and is now happening in England, has already cast its shadow on this country. The physicians of America will do well to heed the warning that sounded from across the sea and continue their organized and united opposition to socialized medical and health programs which have proved themselves detrimental to the health and welfare of the people and a menace to the scientific, economic and social security of the profession.

On Telling the Patient Too Much

How much or how little a physician should say in answering the questions of an inquisitive patient regarding the medication prescribed in the treatment of the patient's ailment is a perplexing question which every physician must answer sooner or later.

Obviously, the physician must have the confidence and good will of the patient to get results, and the patient, in most cases, deserves a frank and honest opinion from his medical adviser. On the other hand, there are instances when both the physician and the patient would be better off if the patient asked fewer questions and the physician answered still fewer.

A recent case arising in an Indiana city illustrates the point. A physician gave his patient strychnine and galvanism for a paralytic condition that had existed for some months. He told the patient the nature of the medication. Later the patient sued for damages, alleging disability due to the strychnine, labeled in the complaint a deadly poison.

Commenting on the case editorially, the *Indiana State Medical Journal* said:

"This should be a lesson to those physicians who glibly tell their patients the kind of medication being prescribed. It stands to reason that the average patient knows nothing about the therapeutic effects of drugs or the indications for their use, so what is to be gained by informing him of the nature of the medicament prescribed for him and give him cause for misinterpreting the reasons for its use? Furthermore, why contribute to self-prescribing, which not only has been very injurious to a great army of people but had led to the enormous and indiscriminate sale of proprietary remedies? The intelligent physician has no apologies to offer for his therapy, but there is no logical reason why the average patient should be given an opportunity of misinterpreting the indications of value of the treatment, or misuse it in connection with his own disabilities or the disabilities of relatives or friends."

Intestinal Diverticuli

George L. Lambright, M.D,. F.A.C.P., Cleveland, Ohio

MODERN methods of diagnosis show diverticuli fairly common in the gastrointestinal tract, when *X*-ray is employed. Cruveilhier in 1849 and Virchow in 1853 described the intestinal pockets found at postmortem. Moynihan called attention to the mimicry of malignancy by the condition in the large intestine before London Clinical Society in 1907. Mayo and Wilson in the same year reported five cases at which operation diverticuli were found when malignancy was suspected. Telling in 1908 wrote a treatise on it, and Abbe in 1914 diagnosed a case preoperatively. Case has written numerous splendid articles on the subject.

There are true and false diverticuli. The true are congenital and are hernias of the entire intestinal wall, as in Meckel's diverticulum. The literature contains more references to true diverticulum than the false on account of the presence of acute symptoms of obstruction and hemorrhage with the former. The false or acquired diverticuli are hernias of the mucosa through muscular layers of the bowel, carrying serosa before the hernia. They are quite often latent and symptomless, and the bowel may be said to be in a state of diverticulosis.

Types are cylindrical, conical or lobulated. The most common site is in the large bowel on the left side, particularly in the sigmoid portion. Deep haustrations with stasis, infection, and increase in intestinal pressure are probably causative factors as described by Masson. Drummond states that the blood vessels enter the bowel at the mesenteric attachment which affords ample reinforcement at this point, but those that course subperitoneally and enter the submucosa at points distant leave weakness in the muscular coat. As most instances occur past middle life when the circulation is less efficient in the colon it is possible that this is a factor in weakening the bowel walls. Osler states that false diverticuli were discovered nineteen times in 2000 autopsies at Johns Hopkins Hospital, while only one was discovered in 2382 autopsies at Boston City Hospital. The condition is more common than that as we have found it eight times in 520 gastrointestinal *X*-ray studies.

SYMPTOMS

These depend upon location and type. An esophageal diverticulum may be small and latent for a number of years before dysphagia, regurgitation, substernal pain and emaciation lead to barium meal investigation. Duodenal and jejunal diverticuli may also be latent with periodical attacks of sharp epigastric pain, nausea and vomiting. The symptoms may be easily confounded with an acute gall stone or duodenal obstructive attack. In the large bowel a long continued persistent constipation, colonic distress, colic, flatus, backache, gastric indigestion and decline in health may lead to suspicion of its presence. If there is an acute inflammation in the diverticuli which harbor virulent bacteria symptoms of continued localized tenderness may continue.

With acute attacks and location of pockets in the cecum a diagnosis of acute appendicitis is made. More often a diagnosis of left-sided appendicitis is made. Case speaks of the pseudo-appendicitis type. In the event of suppuration and fistula adjacent organs may be eroded as the bladder in sigmoid diverticuli. This type is properly named inflammatory diverticulitis. When bowels are adherent and plastic material is thrown out around the walls the name of hyperplastic diverticuli is fitting. In those that are predisposed by inheritance to cancer the site of the diverticulum may be the origin of cancer. At the Mayo Clinic 30 per cent were found to be cancerous when obstructive symptoms had developed. In the event of the abscess and cancerous mass intermittent obstructive symptoms develop and a mass is palpated in the abdomen.

DIAGNOSIS

Until the introduction into wide use of *X*-ray the finding of diverticuli was limited to autopsy and surgical exploration. No advance in clinical diagnostic signs has been made to date. Those who use the *X*-ray as a routine in gastrointestinal complaints are often surprised by its presence in absence of symptoms. In a person over 40 years of age who complains of colicky pains, unexplainable distress, flatus, periodical diarrhea, indigestion, mucoid or sanguineous stools, with decline of health it should be thought of. There will be no physical signs evident beyond a slight amount of abdominal tenderness. In the descending colon the appearance of a palpable mass coexistent with pain, and disappearing a few days later, with blood in the stool is highly diagnostic. If hyperplastic reaction develops the mass will be constant, and obstructive symptoms of partial or complete nature develop. In duodenal diverticuli the symptoms are obstructive and confused with gall stones.

Diverticuli in the pelvic colon may become inflamed, acute abdominal pain with vomiting follow. A leukocytosis may be found and left-sided appendicitis diagnosed.

TREATMENT

Diverticuli which are not hyperplastic, obstructive or ulcerative may be treated palliative with complete relief of symptoms by diet and avoidance of cathartics. Bismuth is very helpful. Bromides and atropine are necessary to control



Case III. Multiple conical duodenal diverticuli with partial obstructive symptoms, diagnoses without X-ray study cholelithiasis.



Case IV. Multiple colonic diverticuli with dull left sided abdominal pain, malena, constipation, flatus. Medical relief of symptoms. Patient aged 70.

muscular spasm. Curative treatment is entirely surgical. With obstructive symptoms and mass there is no alternative except surgical intervention. In young or patients in middle life it is best to surgically remove the diverticuli.

An example of diverticuli of the sigmoid portion of the colon with hemorrhage is the following case:

Case 1.—A male, married, fifty-seven years of age, engaged in executive work in a large manufacturing concern had always been well until seen in 1919. He complained of a dull pain in the left side of the abdomen, constipation of a spastic nature, a distressing full feeling in the abdomen after meals, and the passage on several occasions of blood from the rectum. In the examination of the abdomen some tenderness on the left side was found over a spastic descending colon. The hemoglobin had been reduced to 60 per cent and the cells to 4,100,000 per cm. *X*-ray revealed cylindrical diverticuli throughout the sigmoid and lower half of descending colon. On account of the hemorrhage and his age with cancer possibilities he was referred to a surgeon who removed the diverticuli. An opportunity to re-examine this person occurred in April, 1930. All symptoms of pain and hemorrhage were relieved by operation, and his secondary anemia disappeared. He still has spastic constipation, distention, marked flatus, and a few diverticuli in the lower portion of descending colon.

Case 2.—Diverticulosis in a male, thirty-three years of age, executive, married, who was seen in 1923 when he complained of poor health for over ten years. During this time he had been subject to attacks of generalized abdominal tenderness and frequent mucoid stools. He was chronically fatigued, complained of stiffness in the fingers, mental depression, and numbness in the arms and legs. He had been gaining in weight and looked well.

In the examination there was found submetabolism, soft edema of the skin, hypopituitary obesity, and multiple small diverticuli in the descending colon. The intestinal symptoms were relieved by low residue diet, bismuth, and agar.

Case 3.—Male, widower, aged 64, a freight conductor, a diagnosis of gallstones had been made which could readily be agreed with if a gastrointestinal *X*-ray examination had not been made. There had been attacks of colicky epigastric pain radiating through to the back, accompanied by nausea and vomiting. Between attacks, a heavy distressed feeling was felt in the stomach. Localized tenderness was present in the epigastrium and right subcostal region. Barium meal revealed two conical diverticuli in the descending portion of the duodenum. This is a case of diverticulitis. Operation was advised and refused. Patient was placed on non-irritating diet to small intestinal mucosa, restrained from heavy lifting, and given alkaline powders with bismuth. Word has been received frequently from this party during the past three years during which time he has remained in good health.

Case 4.—An example of diverticuli with hemorrhage in a person 70 years of age. Her complaints were dull pain in the left side of the abdomen radiating through to left flank, stubborn constipation, generalized abdominal soreness, recurrent attacks of passage of blood from the rectum, flatus, and belching of gas. Symptoms had been present for fifteen years. She was subject

to attacks of colitis. A year previous to being seen she was seen by a surgeon who advised exploration for malignancy. No palpable abdominal mass was present but generalized abdominal tenderness was present. The stool contained macroscopic blood. The blood count was normal. *X*-ray showed multiple pelvic and descending colon diverticuli. Diet, acid, and bismuth with agar and oil relieved all symptoms, but of course did not cure the diverticuli. Symptoms have been relieved for three years.

Case 5.—A very unexpected diagnosis in a widow, 43 years of age, who had rather a marked hypertension with many attacks of persistent vomiting, without any epigastric discomfort preceding the vomiting. Uraemic vomiting was the diagnosis when first seen. This was soon found to be incorrect but the cause of the vomiting was not discovered until a gastrointestinal *X*-ray showed one large sized diverticuli in the first portion of the duodenum which produced intermittent obstructive symptoms. The diverticulum was removed surgically with complete relief of the gastric symptoms.

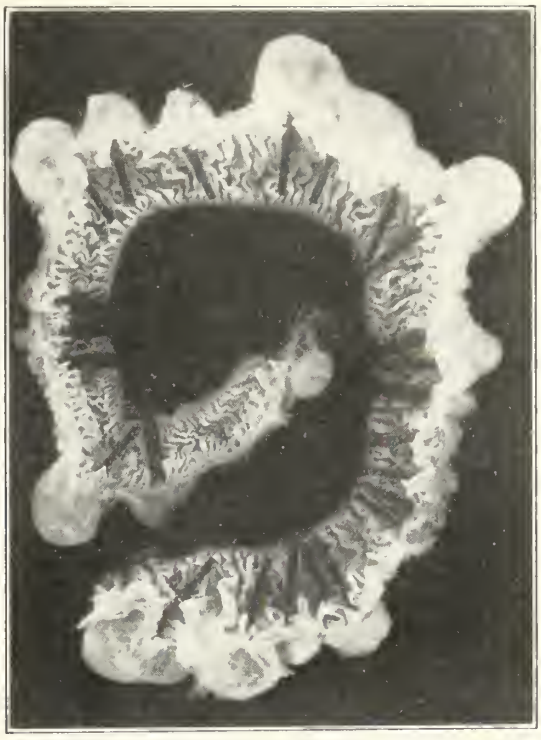
Case 6.—Widow, fifty-seven years of age, who had been subject to migraine until menopause. She had had her gall bladder removed. She complained of pyrosis, pains in abdomen, constipation alternating with looseness of the bowels, backache, and large amounts of flatus. Symptoms had been present for ten years. Only tenderness was found on abdominal examination, and the diagnosis was made by *X*-ray when multiple diverticuli were found in the pelvic colon. Her symptoms have been completely relieved during the past five years by diet.

Case 7.—A patient of Dr. Theron S. Jackson, and I am indebted to him for the following notes: She was a married woman, aged 40, seen September 20, 1929, on account of pain in epigastrium, nausea and vomiting. Some relation of attacks to cold food. There was a leutic history with positive blood findings. A decline of weight had been produced by thyroid extract just before seen. Beyond some sacral backache she considered her general health good. Physical examination revealed absent knee reflexes but no abdominal findings. Diagnosis was made by *X*-ray which disclosed a large conical diverticulum in the region of ampulla vater. At operation multiple diverticuli in the jejunum close to mesenteric attachment were found, necessitating removal of 50 cm. of the jejunum. Many of the diverticuli were thin walled with thickening of serosal surface, thickening of submucosa with edema and engorged dilated blood vessels. All symptoms were relieved following operation.

The last case was found in a male, retired, 63 years of age, who had been under observation for a number of years for mild hypertensive cardiovascular disease, spinal arthritis, hypothyroidism, and bladder papilloma. In October, 1930, he started to complain of distressed feeling in epigastric region and belching of gas after meals. There was epigastric tenderness. The bowels were regular without malena. An *X*-ray examination showed two very large duodenal diverticuli with eight hour stasis. Palliative treatment was used in this case with entire relief of symptoms.

SUMMARY

A short summary of history of discovery of diverticuli is given with description of types, pathology, diagnosis and treatment.



Case VII. Pathologic specimen of jejenum, measuring 50 cm. removed by operation, which shows numerous various-sized diverticuli.

Seven brief case histories are given illustrating points.

Finally the notes bring the disease to our mind again and emphasize the value of *X*-ray in diagnosis in this condition.

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Surgery, With Special Reference to Podiatry, by Edward Adams, M.D., professor of surgery, Institute of Podiatry, New York City; International Journal of Surgery Co., publishers, New York City; price $5.00.

The Treatment of Varicose Ulcers

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THE true varicose ulcers are the most common of all ulcers of the leg but it has been noted that nearly all types of these skin lesions are the result of some change within the vascular system.

The treatment of true varicose ulcers depends upon the removal of stasis of the venous circulation and stimulation of the lymphatic drainage of the foot and leg. If it were not for the secondary infection present in every varicose ulcer, then occlusion of the superficial venous system would soon eradicate the ulcer but this is not a safo procedure until the ulcer has been healed completely. These lesions are all infected and must be treated with this in mind.

There have been several methods of treating varicose ulcers advocated, each based on supporting the venous system and many attempting to apply antisepsis to the ulcer itself. Some have shown fairly good results, but each has its advantages and its disadvantages. Elastic bandages, elastic stockings and the Unna Boot have been the most popular within the last few years.

Resection of the varicose veins has been utilized for treatment of varicose ulcer but this method should not be utilized because of the possibility of severe infection resulting and because of the possibility of infected emboli which has even caused death. Injection of the various veins for varicose ulcer has been a rather dangerous procedure also, because of the amount of infection always present in varicose ulcers.

The idea of the application of the Unna Boot was that of Professor Unna of Vienna and changed some by Dr. Oschner of Chicago. The present, most satisfactory, combination is that of Dr. Joseph W. Sooy of Baltimore, who has added an antiseptic and has made the boot much more elastic and pliable. This allows for greater comfort to the patient in walking and a more truly even pressure at all points from the toes to the knee. It is even more porous than the original paste and allows for the automatic removal of drainage from the ulcer. The formula of Dr. Sooy follows:

Glycerin	1900 gms.
Gelatin	625 gms.
Water	1900 cc.
Zinx oxide	250 gms.
Phenol	1.50% of total volume

Ten pounds are sufficient for seven dressings.

When the patient is able to remain with the leg elevated for some period of weeks, varicose ulcers will usually heal fairly readily and with a soft, firm and pliable scar. The average patient, however, is unable financially or otherwise to remain in bed over such a period of time as is necessary to heal such an ulcer. The usual antiseptic dressings and pressure pads have failed to give satisfactory relief. The ulcers have not healed except with thick, very irritable scars. Elastic bandages will not remain in place if the patient is ambulatory. When the elastic bandages aro properly applied and antispetics are used on the ulcer, it may heal but it is quite impossible with a patient moving about to keep the bandage in place. The support is not even to all parts and the results are usually very unsatisfactory.

Elastic stockings have been used with antiseptic dressings but in walking, the stockings slip, stretch and do not give an even support which is necessary in an ambulatory patient. The pure rubber stockings are quite unsatisfactory because of the perspiration resulting and the skin being continually moist. Silk and rubber, and cotton and rubber stockings, if properly fitted, do quite well for a fair length of time. But they soon stretch and fail to give proper support. The original Unna Boot required a window at the site of the ulcer because of infection. This allowed for pressure at all places except over the ulcer which likewise needed support. With the opening, it is quite impossible or rather unsatisfactory to keep an even pressure over the ulcer as well as the remainder of the foot and leg.

The original Unna Boot was too rigid and pressure sores soon developed about the heel and ankle, the skin became irritable and there was no antiseptic to care for any infection. To the modified Unna Boot, which is slightly more elastic than the original, but which gives the original firm and even pressure, has been added a small amount of antiseptic, namely phenol. The most disturbing factor in the rational treatment of varicose ulcer, is infection. This can be satisfactorily combated by the use of a small amount of phenol which not only cares for the infection at the site of the ulcer but also keeps the skin under the remaining portion of the boot fairly dry and in good condition.

The only patients who fail to respond to this treatment are those individuals who stand for many hours each day without walking, such as an individual who is standing before a lathing machine. An individual may stand many hours a day if every few minutes during that time, he merely takes a few steps. This is necessary to force the venous blood toward the heart as well as to force the upward flow of the lymph through the lymphatics. Many men have failed to get results with the use of modified Unna Boots because they have applied the boot and left it intact for a period of six

weeks without change. Upon removing the boot, they find the ulcer has failed to heal or the ulcer healed but with a thick heavy rather irritable scar. This is the result of the infection being removed but the new skin and scar being entirely closed away from the air. This is overcome by removing the boot at the end of seven days, having the patient with the leg elevated, washing thoroughly with soap and water, scrubbing and even cleansing well the ulcer. This exposure should be for at least an hour before reapplying the new boot, which should be replaced at weekly intervals, then, until the ulcer is completely healed.

In the large lesions, it is necessary to apply between eight and ten boots. You will notice that the ulcer is not healed quite as quickly by this method many times, as leaving the boot for six weeks and then removing it. However, the scar resulting is of a very much more pliable and firm character.

The chief difficulties incurred are in the smoothness of application. In severe malnutrition, diabetic patients with varicose ulcers will respond readily if the arteries are palpable and pulsating below the site of the ulcer. It is necessary, however, that this type of individual neither sit nor stand for a very great time, that is, for more than half an hour at any time. They must move or else have the extremity elevated. Individuals who are malnourished, will not respond until the anemia is at least partially overcome.

The application of the boot is very important. The even application is much more necessary even than in applying a plaster cast. Remember that the skin must receive no irritation. There should be nothing between the skin and the first layers of the boot which might wrinkle, slip or bunch, such as cotton wadding, sheeting, etc. The first layer should start at the base of the toes and encircling the foot, enclosing the ankle and extending to immediately below the knee. This layer must be absolutely even with no wrinkles nor turns which produce any added thickness. It should be moderately firm for at least the first three boots. The Unna paste is then painted or brushed upon this layer. Every successive layer should be applied quickly, the paste applied quickly and evenly distributed, remembering there must be no wrinkles and no bunches of any sort. From four to six layers of gauze bandages are used to make one boot depending upon the site, type and severity of the varicose ulcer. The skin remains in a better condition and there is less irritation about the opening at the heel if the Unna paste is painted on the extremity from the toes to the knee immediately before applying the first layer of the boot. In painting the leg, always paint the ulcer as well as the remainder of the extremity below the knee. One or two layers of gauze bandages are applied over the boot to keep the Unna paste from sticking to and soiling the stockings. This may be removed by the patient and reapplied as desired. Keep the leg elevated for at least an hour after applying the boot to allow it to become thoroughly dry, then trim the boot to allow free motion of the toes. Trim the heel so that the heel is exposed. Trim in back of the knee so that it may be flexed to a 90 degree angle and with comfort to the patient. I believe the patient has more comfort if there is an added two or three layers about the ankle and foot, being applied in a figure of eight.

The patients complain about the first boot, saying that they are not able to walk as freely as previously but that their pain is practically gone. By the second application their pain usually has entirely disappeared and they are very comfortable during the remainder of the treatment.

When the ulcer has healed completely, there are three processes which have been used satisfactorily. The first one is the continued use of silk and rubber or cotton and rubber stockings and the elastic bandage. This procedure is used in elderly individuals who are not very ambulatory and who prefer the discomfort of varicose veins to any surgical procedure. The second method is that of resection of the veins. In selected cases where there are very large veins, seen especially in the popliteal fossa, it is a wise procedure to remove those veins and then to inject at a later date the remaining varicose veins. The third procedure is that of injection of the veins after the ulcer has entirely healed. This procedure is the safest and most satisfactory treatment when the veins are small or medium sized. It may be attempted in the larger veins but is not ordinarily satisfactory.

The following are two cases which had failed to respond to other treatment.

REPORT OF CASE

Case I.—A. M. S.—Female, aged 61, white, with severe varicosities in both lower extremities from the popliteal fossa well below the ankle. Health—moderately well except for chronic constipation resulting from peritoneal adhesions as a result of a general peritonitis at age 36. In July, 1927, was stung at the midpoint of the shinbone between the ankle and knee by an insect. Within half an hour, there was a marked subcutaneous hemorrhage about this point. Pressure was applied by a bandage which was removed within 24 hours, leaving a marked discolored area. The area became red and inflamed within a few more hours and the skin broke down, leaving an ulcer the size of a silver dollar which drained considerably for several months. Antiseptic dressings of Balsam of Peru were applied but showed no improvement after several months. X-Ray was used which proceeded to irritate the area but allowed for no healing. September, 1928, she came under my care and I applied an Unna Boot. The ulcer at the time that I first saw her measured 5½x4½x3 centimeters with thick indurated edges with an irritated surrounding skin. She immediately told me that her pain was practically gone and now she was able to walk in comfort. On removing the fourth Unna Boot there had been a puckering of the underlying vein and this ruptured. The ulcer was about 2x1x1 centimeters.

A sterile pressure pad was applied only over this site and another boot applied immediately. On removing the boot, the subsequent week, the healing had been sufficient to force the vein back into place. It had scarred sufficiently so there was absolutely no bleeding. At the end of nine weeks, the ulcer was healed with a soft, pliable, firm, not tender scar. The patient speaks of no discomfort and is able to go about her daily routine. There has been no tendency to recurrence of the ulcer even though the patient is on her feet from early morning until late at night. She refuses injection of the veins and is wearing silk and rubber stockings.

Case II. A. B.—Female, aged 88, white, physically that of a senile and aged woman. First saw her November, 1928. Deformed in many ways, severe hypertrophic arthritis with poor circulation as a result of a poor myocardium and mitral stenosis, blood pressure 190/110. Marked arterio-sclerosis. Varicose veins severe in both extremities with a bunch in the left popliteal fossa the size of a fist. Varicose ulcer in the left leg at the midpoint between the ankle and the knee completely encircling the leg and being eleven centimeters at the widest point. The patient was ambulatory and had had the ulcer for about 16 years. She had been treated with several methods, had worn cotton and rubber stockings for several years but the ulcer continued. Nine Unna Boots were applied at weekly intervals at which time the ulcer was entirely healed. The comfort of the patient was perfect after the first day of wearing the first boot, the patient stating that she had not been free from pain during that 16 years until after this boot was applied. After the ulcer was healed, the patient wore silk and rubber stockings with perfect comfort until her death in June, 1931, from an acute heart failure as a result of pneumonia.

It is my belief that the most satisfactory treatment for varicose ulcers is a modified Unna Boot as given by Dr. Joseph W. Sooy, with the added insistence of weekly removal and replacement of another Unna Boot until the ulcer is healed.

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Intraspinal and Intravenous Anesthesia

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SPINAL anesthesia is but a revival of an old method originated by Corning in 1885, while sodium amytal intravenous anesthesia was popularized by the reports of Zerfas and McCallum[1] in February, 1929, and Lundy[2] in April, 1929.

Our experience with spinal anesthesia has been limited to conditions below the diaphragm, but the reports of Koster and Kasman[3] indicate that the diaphragm is not the safe upper limit of the anesthesia.

Among the early drugs used and abandoned are cocaine, because it produced perilous signs and toxic symptoms, and stovaine, because of its destruction to nerve tissue. Apothesine and butyn are still used to some extent but often one to two hours after injection produce severe vasomotor reactions with the blood pressure becoming imperceptible. Novocaine, neocaine or procaine affect the vasomotor system less than any other drug used and produce splendid relaxation.

In any of the usual operative cases spinal anesthesia may be used. Some of the real indications for its use are conditions of altered blood chemistry, pulmonary diseases, the aged, advanced cardiac diseases, anemias, arteriosclerosis, unusual alterations in blood pressure, nephritis and chronic alcoholics. Localized peritonitis, infections about the site of lumbar puncture, intraspinal tumors, and advanced hypertrophic arthritis are contra-indications.

There were 5217 cases operated upon at the City Hospital of Akron from January 1, 1929 to September 30, 1930, with 153 cases (2.9 per cent) having spinal anesthesia. An analysis of these cases shows the youngest patient to be 16 years of age, the oldest 72 years, with the average 41 years. Seventy-nine were females and 74 males.*

Preoperative medication consisted of some barbituric acid sedative the night before together with morphine sulphate gr. ¼ and scopolamine gr. 1/200 or atrophine sulphate gr. 1/150 given one half hour before operation.

The spinal injection was made in the third or fourth lumbar interspace in all but two cases. From two to three c.c. of spinocaine was injected in 137 cases, two grains of apothesine in five cases and 100 to 200 m. grams. of neocaine in 11 cases, resulting in a good anesthesia in 128 cases, fair in 21 and a failure in four. In 27 cases some form of supplemental anesthesia was used.

Seventy-one were abdominal operations, 18 of the lower extremity, and 64 rectal or perineal. The operative time average was 43 minutes. Nausea and vomiting occurred in about 20 per cent of the cases, some being relieved by inhalations of oxygen. Several had vomited before the operation.

Four patients had retention catheters in and 55

* Case reports are from the City Hospital of Akron.

** Read before the Union Medical Association of Sixth Councilor District, October 8th, 1930. Kent, Ohio.

had to be catheterized. Only one case showed a post-operative exacerbation of the 37 cases known previously to have a kidney condition. One case of prostatectomy with bilateral nephro-lithiasis had an anuria on the third post-operative day lasting about 24 hours, while another case had an incontinence of urine for two days.

None of the ten cases of headache were of the intensity attributable to lumbar puncture or change in spinal pressure.

Three-quarters of a grain of ephedrine sulphate in 1 c.c. of 1 per cent novocaine solution, as recommended by Pitkin[4], generally carries the blood pressure within normal limits. Three of the cases dying within 36 hours following operation had a pulse pressure between 20 and 24 during their operation. There were ten deaths in the series.[5]

In summarizing spinal anesthesia we note the following:

In 56 cases spinal anesthesia was used because of some contra-indication to inhalation anesthesia.

The complications were less than would have been expected from other types of anesthesia while fewer cases had to be catheterized.

Fluids could be given before, during and after operation in many cases, and the diet increased rapidly.

There was considerable less gas and distention with earlier normal evacuation of the bowels.

Shock was minimized.

Intravenous anesthetics are devoted almost entirely to the barbituric acid compounds. Since 1902 they have been used orally to produce mild hypnosis. In 1923 the first experimental work was done by the intra-muscular and intravenous methods of using the derivatives of barbituric acid in experimental animals by Shoule and Moment.[6] It was not until 1929 that Zerfas and his co-workers[1] reported upon the induction of anesthesia in the human being by the intravenous use of sodium-iso-amyl-ethyl barbiturate (sodium amytal).

The administration of intravenous sodium amytal is simple. The sodium salt and triple distilled water come in separate ampoules and are mixed under aseptic precautions, immediately before injection into the vein, to make a 10 per cent solution. The injection is done at the rate of 1 c.c. per minute. The patient is usually asleep before 5 c.c. is given, without any excitement and no fear attendant upon going to the operating room.

From August 1, 1929 until September 1, 1930, there were 31 cases in which sodium amytal was used intravenously to induce anesthesia at the City Hospital of Akron. The youngest patient was 21 years of age, the oldest 76 years, and the average age 40.5 years. There were 21 females and 10 males. The operating time varied from 25 minutes to 135 minutes with an average of 72 minutes.

Pre-operative medication consisted of chloretone gr. X the night before operation and repeated one hour before operation, with morphine sulphate gr. ¼ and either atrophine sulphate gr. 1/150 or scopolamine gr. 1/200, one-half to three-quarters of an hour before operation.

The dosage of sodium amytal varied from gr. VII to XXII. Our first cases were given the drug with the idea of total anesthesia, but the experimental reports warned against this and advocated smaller doses of the sodium amytal with some supplemental anesthesia. Nitrous oxide and oxygen was supplemented in 19 cases and ether in one case. The amount of supplemental anesthetic was reduced to 25 per cent of the average amount used, where sodium amytal was not administered.

Types of operations—Six thyroidectomies; eight thoracoplasties; one radical breast amputation; seven pelvic operations (including one resection of the rectum); two lower extremity operations; seven upper abdominal operations (two of which were gallbladders and five intestinal operations).

Complications—There was no nausea or vomiting during the administration of the anesthetic or within 24 hours after the operation.

Some drop in blood pressure was recorded in every case during the ten minutes of administration of the anesthetic. The average systolic fall was 40 plus m.m. of mercury and the average diastolic 23 plus m.m. of mercury. A rapid rise to normal limits usually took place within the succeeding 10 to 30 minutes. In most cases the blood pressure would remain within normal limits during the remainder of the operation. In four cases the blood pressure again descended to low limits following the initial rise, but in each case was readily controlled by hypodermic injection of 5 to 10 minims of 1/1000 adrenalin chloride solution. The case having the greatest fall in blood pressure was a 76 year old female with a high intestinal obstruction, due to a stone in the jejunum, and a hypertension upon admittance of 230/130. During the 10 minutes administration of XV gr. of sodium amytal the blood pressure dropped to 110/80. In the succeeding 20 minutes the pressure rose to 160/130 where it remained until the end of the operation. This patient made a good recovery.

The pulse varied but little during the operations and the volume remained good. The higher the basal metabolic rate the greater the dosage of sodium amytal necessary to get the desired result.

Respirations were shallow, as in deep sleep, and usually varied in rate with the pulse. Only two cases showed any tendency to cyanosis, both being thoracoplasties for pulmonary tuberculosis and easily controlled with oxygen. Oxygen was used freely during most of the operations. Carbon dioxide (5-10 per cent in oxygen) was given at the completion of the operations to stimulate the respiration and thoroughly aerate the lungs, as a prophylactic measure against atelectasis and

pneumonitis as recommended by Coryllos,[7] and Henderson and Haggard.[8]

We warn against the use of too much carbon dioxide in pulmonary tuberculosis cases where the deep inhalations incited by the gas might break down protective adhesions or open healed lesions.

After returning to the room the patient's position was changed frequently and tight dressings or bands were prohibited for at least 72 hours. There was no post-operative case of pneumonia or atelectasis in this group.

The average post-operative first voiding time was 23 hours.

Twenty-five cases of this series had some kidney pathology before operation as shown by urinalysis, blood urea, non-protein nitrogen, or phenolsulphonphthalein tests. Eight cases showed some post-operative exacerbation of the condition, nine cases were unchanged, while eight cases showed improvement.

The fluid intake was 3.7 times greater than the output for the first three days in this series, which shows a definite oliguria without evidence of actual kidney pathology and conforms to the findings of Bourne, Bruger and Dreyer.[6]

The blood chemistry remained within normal limits.

Sodium amytal results summarized: 1. Sodium amytal induced a quiet sleep from which the patient could readily be aroused to cooperate in a rational manner. 2. There was no post-operative mania or excitement. 3. An amnesia for two to five days following operation was common. 4. An increased basal metabolic rate requires more anesthetic. 5. There was an absence of nausea or vomiting induced by the anesthetic. 6. Post-operative gas and distention was not present in any case of this series. 7. The cough reflex was not abolished. 8. The blood chemistry remained within normal limits. 9. There was definite oliguria with no kidney damage. 10. We saw no deleterious effects from fluctuating blood pressure. 11. The convalescent time, if not shortened, is at least made more pleasant.

*** Since the presentation of this paper 3819 more cases have been operated upon, 289 cases (7.6 per cent) being under spinal anesthesia, 114 cases (3 per cent) under aertin, and 5 cases (0.1 per cent) with intravenous sodium amytal.

We attribute this popularity of spinal anesthesia to its ease of application, to its increasing number of indications and its post-operative results.

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Ptosis

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PTOSIS as applied to the abdominal viscera is a subject of much greater import than is evidenced by its discussion in our medical societies and journals. Its underlying or fundamental cause is the same as that of hernia, namely, too long mesenteric attachments permitting unusual mobility of the sustained or supported structures, the results of which are angulations of the intestine, stasis of both intestinal contents and the vascular supply, as also lymphatic stasis.

The disturbance to the circulation results in disturbance not only of the peristaltic action of the intestinal wall but marked interference with intestinal secretion. These, together with the disturbed inervation resulting jointly from these disturbances of vascular and lymph circulation, can but produce not only intestinal stasis with a consequent toxaemia, but also a tendency toward intestinal adhesions because of the fact that the intestinal loops not only are in close contact but because of the points of angulation they become inflated or distended by gas, the peritoneal surfaces in close contact under pressure with resultant adhesions to further complicate the condition.

Figure 1 shows clearly how this occurs, a marked case of general ptosis. Note that the transverse colon lies well below the umbilicus, in fact almost down to the brim of the pelvis, that there are very sharp angulations both at the hepatic and splenic flexures of the colon while the small intestines all lie in the pelvis. Figure 2 shows the stomach in transverse position, markedly inflated and its lower border resting one and one-half inch below the umbilicus and the transverse colon lies at the brim of the pelvis and the small intestines below. Figure 3 shows another with very sharp angulation at the hepatic flexure, while the sigmoid (which has been injected) lies with its upper portion sharply angulated and almost transverse. Figure 4 shows another with very sharp angulation at the splenic flexure with

Surgeon to White Cross Hospital.



Figure 1

a transverse colon and all the small intestines lying just above the pelvic brim.

It is obvious that to attempt relief to one of these patients by operation would require a very extensive mesenteric shortening, in fact an amount of stitching up which probably would result in such disturbance of mesenteric circulation as to prove fatal. At the same time a glance at these illustrations shows how futile would be the ordinary straight or slightly curved thick ptosis pad applied by means of an ordinary abdominal belt in which the pressure is made directly backward, an attempt to apply the belt with the patient standing, sitting or even in the ordinary recumbent position. They also suggest how marked the intestinal stasis, disturbance of circulation, of lymphatic supply and consequent toxaemia would be. Normal bowel action would be almost if not quite out of the question.

It is true that some or many of our chronic constipations of our persistent toxaemias and our failures to relieve by drug therapy are due to ptosis. They also emphasize that in the treatment of this condition the first essential is to place the patient in a position with the head down and the hips sharply elevated, in order that the viscera may gravitate toward the diaphragm into a more correct position and that a support, to be effective, must then be fitted with the patient in this position so that the pad conforms to the shape of the pelvis, more or less that of a "horseshoe", so that the central or pubic portion will sustain or support the small intestines while the lateral wings support the caecum and ascending colon on the right side and the sigmoid and descending colon on the left side. In order to give an uplift instead of a backward thrust the buckles should be placed upon the abdominal portion of the belt and the straps upon the body of the belt in such manner that when buckled they form an angle of forty-five degrees, so that buckling the straps from below upward they lift the abdominal wall and the underlying contents upward. With such a mechanical support many if not all cases of extensive general ptosis can be relieved and their constipation and toxaemia overcome.

There will be a limited number of these cases so extreme as that illustrated in Figure 1 which no treatment other than that advocated by Sir Arbuthnot Lane can be expected to relieve, that is, by an operation in which the ileum is anestomosed with the sigmoid. In patients where this is found to be necessary the operation should be performed in a manner to preserve the ileocecal valve rather than by making a side to side anestomosis, and it may be necessary subsequently to perform a colectomy.

Fortunately the number of patients requiring such drastic surgery are very few indeed.

I am convinced that those surgeons who use the Trendelenberg position as routine in their abdominal work do not see so large a number of marked ptosis patients as do those who operate with the patient flat. This may possibly explain why so little has been written or published upon this subject.



Figure 2 Figure 3 Figure 4

Lifting the Curse by Removing the Cause of Epidemic Diseases

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THERE is a cause for everything that exists. Diversities that exist in mind and matter are not accidental, but the result of cause and effect.

The creative power of an infinite and Almighty Jehovah was the first cause of all things, and man's violation of Jehovah's righteous law resulted in his expulsion from Edenic happiness and brought upon the human race the divine curse with all its attendant evils resulting in death.

Jehovah God is the God of nature, and all violations of nature's laws are violations of Jehovah's laws, and as such bring evil results; violations of natural laws are continually adding new ills to the human race, which, if properly understood might be avoided.

This fact has long since been recognized, and great efforts have been put forth to trace every human ill to its source and if possible remove the cause. Much progress has already been made in the prevention of epidemic diseases in consequence of increased knowledge of etiology, and the microscopic revelation of bacteria has brought to light many sources of human diseases hitherto unknown.

In ancient times men resorted to fetishes and superstitions, and even today, this is a great barrier to the lifting of the curse and to progress toward human happiness. To the Ancients, and to Medieval man epidemics of disease mysteriously appeared from nowhere and disappeared for no reason. To explain them the stars were called upon; to stay their progress the gods were employed, and sacrifices, prayer and fastings ordained. We now know that they are but the result of the dissemination of minute living entities carried by perfectly natural means from country to country and from man to man, attacking and destroying those weaker than themselves. They have their parallels in the misfortunes of agriculture, such as the occasional devastating appearances of locusts, of army worms, of cutworms, of cotton bolweevils, of gypsy moths, and many other well known enemies of the forests and fields.

But the Ancients were not so restricted in their knowledge of disease, its cause, its cure and its prevention, as many have been lead to believe. Their knowledge of etiology and prophylaxis, crude as it may have been, was used to a good purpose to hold in check and to stay off many human ills.

Babylon had a sewerage system, and brought its water supply a long distance at great expense to have it pure. Later the practice of medicine became well established, physicians were licensed and their fees prescribed by law. Egyptian physicians practiced various specialties and used forms of minor surgery. But the ancient Hindu excelled all others of their day in the art of surgery.

The ancient Hebrews conceived disease as an expression of the wrath of God, to be removed by moral reform, prayers and sacrifices. They ordained forms of medical jurisprudence and established public health bureaus. The valley of Hinnom was used as a garbage disposal works for the city of Jerusalem; and Jesus speaking of this valley uses it as a symbol of complete and everlasting annihilation. The Jews prescribed few remedies; they were interested chiefly in the prevention of disease. They quarantined persons afflicted with such diseases as leprosy, and burned their excreta together with any articles which might become contaminated. Lepers were isolated from the company of all others, and upon the approach of any one they were required to give a warning by crying out "Unclean, unclean".

The Persians employed many safeguards against contagious and epidemic diseases. Cyrus the Great boiled drinking water for his soldiers when on his military campaigns, and used every known precaution against disease.

The Greeks gave to the world Hippocrates, who is called the father of medicine; he was the greatest physician of ancient times. He was born in the Island of Cos, about the year 460 B.C. and died in 377 B.C. He was distinguished for his remarkable skill in diagnosis, and his accurate and vivid description of morbid symptoms. Many striking sayings are scattered through his works which have passed into familiar use. Among his genuine and popular writings we note the following:—on "Prognosis", "Aphorisms", "Epidemics", "Diet in acute diseases", "Wounds of the head", and on "Air and water".

The Romans are remembered chiefly for their achievements in hygiene; they provided ventilation for their houses, practiced cremation, and built sewers, drains, public bath pools and great aqueducts. The fall of Rome and the dark age which followed were marked by retrogression in sanitary science. Sanitation gave way to filth and pestilence. War, ignorance, and brutal prejudice appeared to have constituted the ruling spirit, and this period stands out as the most unsanitary era in the annals of history.

In spite of all the progress man has made since

Data has been culled from "The National Institute of Health," and also from Joseph McFarland's book, "Fighting Foes Too Small to See".

the beginning, it was not until the opening of the Nineteenth Century that his knowledge of the human body and the enemies to which it is exposed, made possible the prevention of any epidemic or contagious disease.

In the early part of the Eighteenth Century the Turks were practicing inoculation against smallpox, using matter from the pustules of smallpox patients, but it was not until about the close of the century that Edward Jenner for the first time established the use of vaccine from cowpox in the prevention of smallpox in human beings.

With the discovery of smallpox vaccine by Jenner, in 1796, began the banishment of this dread disease from every civilized country. In spite of considerable opposition, this method of preventing the spread of smallpox was slowly but surely adopted all over the world. It was introduced in Boston in the year 1800, and in New York City in 1801. The result was that smallpox, which according to the *New York Medical Record* of July 14th, 1894, carried off over 15,000,000 persons in Europe during the Eighteenth Century and was the cause of one-tenth of all the deaths in New York City between the years 1785 and 1899, has been practically eliminated except in neglected communities. In colonial days smallpox attacked nearly everyone at some period of life, and those who survived carried the marks the rest of their lives.

Some fifty years after Jenner's discovery, William Budd and John Snow, English pioneers in epidemiology, began their remarkable study of typhoid fever and Asiatic cholera, which, in a great measure, led to the control of these plagues. But the first discovery of what was later proved to be a disease-producing bacterium was made about the year 1850, when the French pathologist Davaine, on examining the tissues of cattle which had died of anthrax, discovered the constant presence of minute rods, shown later by Robert Koch, a German bacteriologist, to be the cause of the disease.

It was not until 1857 that the French chemist, Louis Pasteur, discovered the true nature of the process of fermentation, also a knowledge of the chief maladies which have scourged man and animals, and of the measures by which either the body may be protected against these diseases or the poison neutralized when once within the body. Pasteur showed that the aging of wine by bacteria could be prevented without changing its taste by heating it to a temperature of 55 to 60 degrees centigrade. This principle has since been applied to the preservation of milk, and now much of our milk is kept free from the harmful action of bacteria by this simple heating process, universally known as pasteurization. Pasteur was the first man to demonstrate beyond dispute that all forms of microbian life have ancestors and a numerous progeny, thereby dispelling the idea that they came into existence spontaneously. He held the belief, that it is within the power of man to rid himself of every parasitic disease.

Stimulated by and coincident with the successful investigations of Pasteur, Joseph Lister, an eminent surgeon of Edinburgh, became convinced that many wound diseases were due to germs, and by using antiseptics he soon established his thesis and paved the way to the present practice of aseptic surgery. His work represents one of the most brilliant triumphs in establishing the germ theory of infectious diseases.

Robert Koch, a German bacteriologist, announced in 1882 the discovery of the micro-organism of tuberculosis, causing a profound sensation throughout the world. He proved beyond a doubt that the bacteria of tuberculosis was the origin and the only cause of the long dreaded disease, the Great White Plague, consumption. So conclusive was his evidence that in a surprisingly short time it was universally accepted. The following year, the germ of Asiatic cholera was discovered, and one year later was brought to light the bacillus of diphtheria and also that of tetanus, and further developments regarding the bacillus of typhoid fever. Within very recent years the terrible menace of typhoid has been reduced to a small and still reducible fraction of what it once was. Figures compiled by the Prudential Life Insurance Company, of Newark, N. J. show that the rate has been reduced from 32 deaths per 100,000 in 1901 to 8 in 1925.

Diphtheria is justly regarded as one of the most dreaded of the diseases of childhood. It has come down to us from antiquity under such names as "Egyptian sore throat", "Syrian ulcer", "putrid sore throat", "gangrenous ulcer", "membranous croup", and the like, until the name diphtheria was given the disease by the French physician Bretonneau in the early part of the Nineteenth Century. Until the fruitful discoveries of Klebs, Loeffler, Behring and others, gave us a knowledge of the cause and the methods for the cure and control of diphtheria, few diseases had presented such high mortality, and there had been few before the march of which we were so helpless. An outbreak of diphtheria in a community caused a shudder of horror, for the old records are full of instances where all the children of a family were swept away in spite of all that the medical knowledge of that time could do. But thanks to our modern discoveries, there are now few diseases about which we know as much as diphtheria. Its prevention and control are feasible, provided sanitary authorities and the general public intelligently cooperate.

Yellow fever has been until recently, one of the most horrible and shunned epidemic diseases in the United States. It appeared in this country 112 times between the years 1702 and 1878; being the most frequent and destructive in the southern states, especially in the city of New Orleans. From 1800 to 1879 yellow fever, with two excep-

tions, visited the United States every year. During this period the great epidemics were those of New Orleans, in which there were 290,020 cases and 8,101 deaths, and that of Memphis, with 17,600 cases and 5,150 deaths. Over four and a half million dollars were contributed in 1878 for the relief of the stricken cities of the South, involving a total estimated loss to the country of not less than $100,000,000; the epidemic of 1878 cost the city of New Orleans alone over $10,000,000.

The work done by the United States Army in 1900 under the direction of doctors Reed, Garroll and Lazear, in research work among the yellow fever victims in Havana, proved conclusively that yellow fever is transmitted by the Aedes aegypti mosquito. Soon after this discovery the danger of yellow fever in the United States was virtually eliminated, and in 1905, under the direction of Dr. Joseph White, of the Public Health Service, yellow fever was driven from the southern states.

Typhus fever prevailed in epidemic form in this country well into the Nineteenth Century. Now that the methods of its transmission is understood serious epidemics of this disease need no longer be feared. The difference between the former great, and the present diminished danger, has been brought about not through the discovery of the specific micro-organism, for that has still eluded the search of the bacteriologist, but through the discovery of what is of equal importance, the means by which the disease is spread. The investigations of Nicolle, Couer, and Conseil of France, of Goldberger and Anderson in this country, and of Ricketts and Wilder in Mexico, beginning in 1909, have definitely proven that this disease is transmitted through the bite of infected lice. This disease is not contagious in the ordinary sense; it cannot be caught from the patient; and if the lice are prevented from passing from patient to doctor or attendant, there is no transmission of the disease.

Bubonic plague killed approximately one-fourth of the population of Europe in the middle ages. Within a generation the means of its control has been learned. Even at the present time, in places where sanitary measures cannot be enforced, the disease spreads, and people die in great numbers. Thus, in India in 1901, there were 362,000 cases with 278,000 deaths. In the first six months of the epidemic in 1907, the deaths in India were more numerous, reaching a total of 1,062,908. But where sanitation is possible and cooperation between the authorities and the people succeed, as in New York, San Francisco, and other American ports to which the infection was brought, the disease did not spread. Plague seems to be primarily a disease of the lower animals, such as marmots and rats, and only secondarily, and one might say accidentally or incidentally, a disease of human beings.

Our forefathers feared with reason Asiatic cholera, which is no respecter of climates. Science has made this disease a vague memory among the peoples of the United States and Europe, but it is still destroying many millions of human lives in India. It is probable that malaria was more responsible for the decline of the culture of both Greece and Rome than any other single feature. At the present time even this disease can be controlled.

Among several scientific aids developed within the last century, the *X*-ray has been of incalculable value in the study of many diseases and has helped materially in their conquests. It is difficult for one who has not made a special survey of the history of epidemic and contageous diseases to realize under what improved health conditions we are now living in this regard.

In marked contrast to the decline of infectious and communicable diseases is the trend of the death rate from degenerative diseases, such as affections of the heart, Bright's disease, diabetes, cancer, apoplexy, influenza and pneumonia. Not only has the death rate from these degenerative diseases failed to decline, but it has actually increased at a rather rapid rate. Diseases of the heart and circulatory system has increased from 70 per 100,000 in 1870 to over 300 in 1920. Where Bright's disease caused 50 fatalities per 100,000 in 1870, it now causes almost twice that number. Apoplexy was causing 30 deaths per 100,000 in 1870, today it is causing 100 deaths for the same number of persons. And cancer, one of the most dreaded and deadly of the group, is steadily increasing, until now more than 100 victims per 100,000 are claimed annually, whereas in 1850 approximately 30 fell victims to the disease.

These few examples indicate the potency of scientific investigation to combat the menace of disease and to aid in the release of a greater and stronger man power to do the world's work. The record of the past gives certain promise to the future. A vast field for investigation yet lies before the zealous investigator into the source of human ills. We are now in the dawn of the new age when the light of present truth shines with a brilliancy as never before, revealing to man the hiding places of many of his unseen foes. To "walk in the light" and receive divine approval, we must pursue scientific investigation and apply the benefits of scientific research.

504 N. UNION AVE.

Miss Harriet Jones, Albany, N. Y., was awarded the Henry L. Doherty prize of $500 for the winning essay on mosquitoes in the Fourth Annual Gorgas Memorial Essay Contest. Miss Irene Gerhardstein, Cheviot, Ohio, won fifth prize and honorable mention.

A grant of $14,220 has been granted by the National Research Council for research work at the University of Michigan on drug addiction.

The Diagnosis and Treatment of Uterine Inertia: With Report of 100 Cases*

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THE diagnosis and management of protracted labors due to weak, infrequent uterine contractions confront the obstetrician quite frequently. A review of 1500 consecutive cases delivered at Mt. Sinai Hospital showed an incidence of 6⅔ per cent.

The discovery of pituitary extract by Dale[1] in 1906, followed closely by a clinical report of Blair Bell[2] in 1909 on the value of pituitary extract in uterine atony stimulated considerable interest in uterine inertia.

In America, Eddy[3], Ehrenfest[4], Cragin[5], Humspone[6], Harrison[7], Harper [8], and others dealt with the subject of uterine inertia and the use of pituitary in its management. Of these, only Harper was not a strong advocate of the drug in this condition.

At present pituitary extract is considered dangerous in inertia of first stage due to the possibility of inducing tonic contractions of uterus, intrauterine asphyxia of the child and rupture of uterus.

Temesvary[9] introduced thymophysin—a combination of pituitary and thymus extracts, in 1924. His claim for this combination is that it shortens the first stage of labor by increasing uterine contractions and aiding in the dilatation of the cervix.

Uterine inertia is ascribed generally to one or more of the following factors:

1. Physiologic inhibition of uterine contractions, as, for example, an over-distended bladder or rectum.

2. Inherent weakness of uterine musculature due to infantile uterus, subinvolution, fibroids, fatty infiltration of uterine muscle, over-distention of uterus produced by hydramnios or multiple pregnancy.

3. Psychic influences such as fear of hospital, examination by physician, etc.

While all these factors are frequently associated with uterine inertia, they do not of themselves, necessarily cause the atony. In the present study, malpositions, malpresentations and dry labor were found to be the most common primary causes of the inertia.

The diagnosis of uterine inertia is not difficult. The increased pulse rate of the mother; her general appearance of being tired and exhausted; the uterus retracted over the fetus and in a state of increased tone; uterus not relaxing between contractions; fetal parts not easily or not at all discernible; upward retraction of presenting part; rise of lower uterine segment with increased thickness and tone of the fundus. These signs speak for exhaustion of the uterus as a result of overaction.

On the other hand, a soft, flaccid uterus with fetal parts easily palpable, uterine contractions not too painful, and general condition of mother, especially pulse rate, not markedly affected, justify a diagnosis of uterine inertia.

False labor is differentiated from uterine inertia by the presence of a bloody show and a certain degree of cervical dilation.

The prognosis of uterine inertia for the mother depends upon the time of its appearance. Inertia during the third stage of labor or the early post-partum hours is, of course, the most serious, due to loss of blood.

Uterine inertia is not serious for baby since uterine underaction does not subject the presenting part to undue pressure. Symptoms of fetal distress are an indication that the slow labor is not due to inertia uteri.

Real danger to the baby and mother may result from untimely interference such as injudicious use of forceps with consequent injury to the baby's head and maternal soft parts. The danger of pressure-necrosis during a prolonged labor, while not very common in uterine inertia, is to be thought of in all cases where the presenting part remains stationary for many hours.

THE MANAGEMENT OF UTERINE INERTIA VARIES WITH THE STAGE OF LABOR

Inertia of the first stage of labor is treated best by means tending to conserve the mother's strength. Reassuring the mother that her condition and that of her baby is satisfactory, liquid nourishment and sedatives answer the purpose. If the inertia is due to poorly borne pain, a small dose of morphine may bring about strong uterine contractions.

In rigid, undilated cervix, the treatment consists in the use of a bag. Manual dilation under anesthesia (spinal or general), may be resorted to if the cervix is soft and easily dilatable.

Thymophysin has been used to combat uterine inertia of the first stage of labor with variable results.

L. W. Haynes[10], reports 500 cases of uterine inertia treated by thymophysin. It failed in 40 cases. In 76 cases of induction of labor, thymophysin alone acted poorly; in combination with castor oil and quinine, it gave satisfactory results. In Graff's[11] report of 270 cases of secondary inertia, thymophysin worked best in the first

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stage of labor. In Liebbe's[12] report of 84 cases, thymophysin worked best during the expulsion period of the second stage. Demuth[13] also reports best results during expulsion stage in 150 cases. Ervin Nelson[14] finds no reason to believe that thymophysin acts in any way different than small doses of pituitary extract. Furthermore, the strength of thymophysin examined was found to be 25 to 33 per cent of that claimed on the label.

During 1930, thymophysin was used at Mount Sinai Hospital in eight cases of uterine inertia. Its action was found too violent when used in 1 c.c. doses, and the dosage has been reduced to ½ c.c. When used with caution, thymophysin, as well as small doses of pituitary extract, may be of aid in cases of uterine inertia, especially in cases of secondary inertia when labor comes to a standstill for several hours.

In inertia of the second stage of labor, delivery can be accomplished by the use of forceps or version and extraction. The latter procedure is used more frequently in multipara with fetal head high or unengaged.

The treatment of uterine inertia of the third stage is that of post-partum hemorrhage—pituitary extract, ergot, massage, and packing the uterus.

Pituitary extract contracts the uterus promptly but its action is not nearly as pronounced as during expulsion period of the second stage. An active preparation of ergot is much more reliable and keeps the uterus contracted longer.

Pituitary extract given immediately after delivery of the fetal head aids in the separation of the placenta and renders the third stage shorter and smoother, thus tending to prevent uterine inertia.

Ether used for analgesia and anesthesia during labor has a tendency to relax the uterus post-partum, thus favoring third stage inertia. Nitrous oxid-oxygen analgesia and anesthesia are to be preferred, except when relaxation is needed as in version and extraction.

A comparison of the average duration of labor in 1000 consecutive cases with that of inertia, showed:

Average duration of labor in primipara	19.6 hours
Average duration of labor in multipara	12 hours
Duration of labor in inertia:	
primipara	50 hours
multipara	35 hours

The duration of labor in inertia uteri, then, is three times longer than the average.

Review of 1502 consecutive records showed 100 cases diagnosed as inertia of the first, second or third stage. These were about evenly divided between primipara and multipara, showing that the parity of the patient does not affect the incidence of inertia.

The occurrence of inertia according to stages of labor was as follows:

In first stage of labor	77 cases
In second stage of labor	9 cases
In third stage of labor	14 cases
Character of pains:	
Contractions irregular	19 cases
Contractions regular but weak	42 cases
Contractions ceased (secondary inertia requiring induction of labor)	16 cases

In the sixteen cases requiring induction of labor, castor oil—1½ oz., quinine—gr. 5, repeated every half hour for three doses, and s.s. enema given one hour after the castor oil, was used in fifteen cases with good results. One case required bag induction, and in four cases pituitary extract, M V, was used in addition to castor oil, quinine and enema.

Thymophysin was used in eight cases. It failed in one case. Its action was violent in three cases, patients delivering in thirty minutes to one hour after administration of the drug.

Diagnosis of inertia—(all stages of labor):

1. Ruptured membranes prior to onset of labor	25
2. Malpositions and malpresentations	35
3. Distention of the bladder	5
4. Fecal impaction	1
5. Multiple pregnancy	4
6. Hydramnios	2
7. Pendulous abdomen and obesity	5
8. History of infantile uterus and subinvolution	4
9. Fibroids	2
10. Previous operation for suspension of uterus	2
11. Subjective pain	4
12. Psychic inhibition of pain (coming to hospital and examination by interne)	6
13. Cause undetermined	5
	100

Presentation and position:

L.O.A.	40	
R.O.A.	25	
L.O.P.	3	20
R.O.P.	5	
L.O.T.	7	
R.O.T.	5	
Face presentation	1	15
Breech	4	
Twins	2	
No engagement	8	
		35

Dry labor and malposition, then, are the most frequent causes of inertia; next in frequency is pendulous abdomen associated with obesity and distention of bladder.

TREATMENT OF UTERINE INERTIA

First stage:	
Morphine (alone or with scopolamine)	36
Castor oil and quinine	18
Quinine and pituitary	7
Thymophysin	8
Bag induction	2
Manual dilatation of cervix	6
	77

Morphine was used for the purpose of giving patient rest from ineffectual nagging pains, or to induce sleep.

The Castor oil—quinine—enema combination gives best results when stimulation of uterus is necessary during the first stage of labor. Thymophysin gives good results but its action is violent when used in 1 c.c. doses.

Manual dilatation followed by version and extraction was done six times in three multipara and one primipara with cervix one-half dilated and head high; the other two were delivered by mid-forceps.

Second stage:

Low forceps	2
Mid forceps	2
Version and extraction	4
Craniotomy	1
	9

The craniotomy was done on a dead fetus after mother had been in labor forty hours.

Third stage:

Moderate post-partum hemorrhage	11
Severe post-partum requiring packing of uterus	3
	14

MORTALITY AND MORBIDITY

Maternal Mortality	0	Infant Mortality	4
Maternal Morbidity	6	Infant Morbidity	1

Causes of Morbidity		Causes of Mortality	
Pyelitis	2	Intracranial hemorrhage	1
Pelvic phlebitis	1	Hem. disease of newborn	2
Endometritis	1	Undetermined	1
Foreign body in vagina	1		
Infected repair of rectocele	1		

Infant Morbidity:

Fractured humerous during delivery of breech presentation.

CONCLUSIONS

(1) Uterine inertia is a frequent complication of labor—6 2/3 per cent.

(2) The diagnosis of uterine inertia presents no difficulties.

(3) Uterine inertia is not dangerous to mother or baby.

(4) The treatment of first stage is watchful waiting and conserving physical and mental powers of patient; forceps or version and extraction during second stage; prompt and energetic treatment of post-partum hemorrhage in third stage.

(5) When properly managed, the mortality and morbidity, both maternal and infant, in uterine inertia, should not exceed those in normal deliveries.

10515 CARNEGIE AVE.

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The Perforated Peptic Ulcer

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THERE is no other subject in medicine, so much discussed, as the treatment of peptic ulcer, both before and after perforation. Like the much argued subject of prohibition, each side is prone to quote the statistics which more nearly favor their own opinion rather than that based on good judgment and common sense.

Although there may be a discussion of the other phases of the ulcer question, every one agrees that with a perforation, a grave emergency at once exists and prompt surgical treatment must be instituted as soon as the patient and the surgeon can be brought together. But, we feel that not only the calamity that has overcome the patient should be corrected, but that it should be corrected in such a way that will allow the patient to enjoy the greatest comfort and health throughout the rest of his days. Of course, we do not mean to say that a patient with a gastro-enterostomy is a normal individual, but he is nearer one than a patient with any other type of surgery for peptic ulcer. But after performing the operation, he should be followed up and checked regularly by a medical man. I would like at this time, to make a plea, that not only in perforated ulcer, but in all ulcers, it is not so much a question of medical or surgical treatment, but both. Medical and surgical treatment should go hand in hand, and there is no pathology among the ills of man that responds so well to the intelligent cooperation of the medical man and the surgeon as in the treatment of gastric and duodenal ulcer.

In this review, I do not intend to suggest to experienced surgeons how they should operate, but I do intend to show you what I have found in this short series, and I do intend to tell you what procedure we intend to follow, and then you can do as you please, because I know you will anyway.

This paper is based on a report of all of the cases of perforated peptic ulcer, admitted to the Akron City Hospital from June, 1925 to July, 1930. During two and one-half years of this

period, I was house officer of this institution, and it was my good fortune to assist and personally operate on many of the service cases that were in this series. While not an extremely large series, we have in Akron a very cosmopolitan population and I believe that this series shows a fairly average finding that would be similar throughout the country. I was pleased to find in a fairly extensive review of literature, reports that parallel ours very closely.

The total number of cases admitted and on which this report is based, is fifty-two. Forty-seven were men and five were women. The marked preponderance of men suffering from the condition probably can be explained by the fact that women are much more apt to follow regular diets and regular hours of eating, that their work is less hazardous and that they see physicians sooner than men, when they have any symptoms of illness.

Of these fifty-two cases, thirty-seven were duodenal ulcers and fifteen were gastric ulcers. The type of operation performed was simple closure in twenty-two cases; closure and plyoroplasty in two cases; closure and excision in all forms from simple excision of the ulcer bearing area to sub-total resection of the stomach, in five cases; closure and posterior gastro-enterostomy in twenty-three cases.

The age of perforation varied from the youngest, nineteen years of age, to the oldest, seventy-two years of age. The average of the fifty-two cases was thirty-eight years. The largest number of cases were in the late twenties or the early thirties, showing that this calamity occurs in individuals in the very prime of life.

In this series, there was a total of sixteen deaths, or a mortality of 31 per cent. Where, as is always true in these cases, the mortality was almost directly proportional to the time of perforation as in fourteen of the sixteen deaths, the perforation was over twelve hours' duration. In only two cases was the perforation less than twelve hours. In one of these, death was due to nephritis rather than peritonitis. The average time of perforation for all cases that died was nineteen hours. The average for all cases, surviving and dead was eleven hours. The average time for all cases that survived was eight and one-half hours.

The incidence of time of perforation and operation has decreased each year so that it is very evident that we are now seeing these cases much earlier than before. In twelve of the cases of death, nothing more than simple closure of excision was done. Naturally, many of the patients were poor risks and nothing more could have been done. But, in at least four of the twelve, we believe that a gastro-enterostomy should have been added. In the remaining four deaths, all had gastro-enterostomy performed. One in a patient perforated over sixteen hours and one in a very poor risk because of nephritis. In our opinion, a gastro-enterostomy should not have been done on these two.

The chief question in the treatment of these cases, has been as to whether in addition to simple closure, a posterior gastro-enterostomy should have been done. Since we believe that a posterior gastro-enterostomy should be done in selective cases, it is only fair to state the opinion of the opposed side.

1. It is unnecessary, perforation curing the ulcer.
2. It adds to mortality.
3. There is danger of spreading infection in the peritoneal cavity.
4. It is not satisfactory in 100 per cent of cases.
5. Re-perforation, hemorrhage and stenosis are exceptional sequelae.
6. The danger of subsequent jejunal ulcer.

In the paper, I will attempt to answer these objections in a general manner throughout the discussion, and briefly and collectively at the conclusion.

When cases are reported as cured, after simple closure, we believe they are often due to a failure to follow up the case. Morley, although advising against gastro-enterostomy, found that in eleven out of his forty-one cases, there had been a recurrence after operation. It has often been reported that a gastro-enterostomy, will greatly increase the primary mortality, but published figures do not support this view. Deaver reports in a most successful group of cases, fifty-six in all, that there were only two deaths, the first and the last of the series, and a gastro-enterostomy was done on all of the cases but two. In our series, many of these were service cases, and because the population of Akron is somewhat transitory, we were unable to trace replies, others we finally traced through their attending physicians, or through the Clinic. Twelve of these twenty-three had posterior gastro-enterostomy performed in addition to simple closure. Only one complains of severe symptoms, two others have minor complaints, but after careful questioning, we find that they are very careless in their diet. Nine are free from symptoms from one to six years. Of the thirteen cases that I have been able to trace, who had simple closure or local excision, four later had gastro-enterostomy performed, and one had his gallbladder removed. Three others have had regular medical treatment yet have many of their former complaints, which leaves only five who have been entirely free from symptoms from one to six years.

In our minds there are only two questions to be considered:

1. Should a posterior gastro-enterostomy be performed?
2. Should it be done at the time of operation?

As to the first question, we will always believe that it will be a good thing for a surgeon to ask

himself when operating, "What would I like to have done on myself?" We find that perforated peptic ulcer is nearly always found in a chronic ulcer; therefore, simple closure will not cure them. In this series of fifty-two cases, only two failed to give a history of past gastric distress and more or less treatment from two to twenty years, and we believe that this same circumstance will be found in nearly all cases if a careful past history is secured.

Before doing the gastro-enterostomy, we should first consider why it will or will not be a success. No matter what method is used in treatment, whether medical or surgical, what we desire to secure is physiologic rest. Physiologic rest of the stomach and ulcer area, as rest of any kind in any sickness or injury is the greatest medicine yet invented. A gastro-enterostomy does this:

1. Because it diverts the current of food from the ulcer area.

2. Because it lowers the acidity.

3. Because it overcomes the physiologic resistance of the pyloric end of the stomach, which is the same principle as divulsing the sphincter ani, when operating for rectal ulcer.

The second of these two questions, should it be performed at the time of operation? There should be no question if the patient is in fairly good condition. It should always be done then. If the patient is in poor condition from some outside pathology other than the ulcer, or if general peritonitis is present of course all we can do is to close the perforation and drain well, including the pelvis, and to close the abdomen and hope. Occasionally the Great Physician cures them, but too often the same truth that this same physician taught centuries ago comes to pass, namely that faith without works is dead. Especially is this true when that work comes too late. In all other cases, after closure, posterior gastro-enterostomy should be done. And we feel that the result both from our standpoint and from the standpoint of the patient will be the best possible.

Since many cases are seen earlier now, they can often be closed without drainage. However, the old axiom, "When in doubt, drain" might not be entirely true, yet when any infection of the peritoneum is present, it is better to drain. This is best done by a tube drain in the pelvis, through a stab wound, as the patient is nursed in a Fowler's position. This will secure the best drainage and the tube may be removed in thirty-six or forty-eight hours, if no purulent drainage is present, or kept longer if there is. I believe that this procedure has saved many lives.

A review of the literature studies of this series and a study of the pathology involved in perforated peptic ulcers brings us to the following conclusions:

A. In the old and infirm, in cases of general peritonitis, in cases with heart or kidney lesions, or in any poor risk, simple closure and drainage in all that can be done.

B. In all other cases in addition to closure, a properly performed posterior gastro-enterostomy should be done, because,

1. Ulcers are chronic and perforation does does not cure the ulcer.
2. It does not affect the mortality in properly chosen cases.
3. The danger of spreading infection is of theoretical rather than practical importance.
4. While gastro-enterostomy is not 100 per cent successful in relieving symptoms or preventing them, and no procedure in medicine or surgery is that it is so in such a large percentage of cases that there can no longer be any doubt of its specific effect.
5. Suture always narrows the lumen and the operation safeguards against secondary perforations and subsequent stenosis.
6. While subsequent jejunal ulcers are a possibility to be recognized, the incidence is extremely low, and would be almost entirely abolished with proper medical treatment.

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205 METROPOLITAN BLDG.

A special committee of the American College of Surgeons is making a two-year study of the teaching of surgery in undergraduate, graduate and post-graduate medical schools. The committee is composed of Drs. Fred C. Zapffe, Irving S. Cutter, George J. Heuer, Elliott Cutler and Allen O. Whipple.

Graduation in pharmacy itself does not necessarily constitute a preparation for the study of medicine, and pharmacy school graduates applying for matriculation in medicine should not be granted premedical credit except with the approval of the executive council of the Association of American Medical Colleges, according to a resolution recently adopted by that association.

Annual convention of the Ohio State Pharmaceutical Association will be held July 18 to 22, inclusive, at Cedar Point.

Beware of Many Types of Collecting Agencies to Which Delinquent Accounts of Patients are Referred

Collection of medical fees, a bugaboo to practically all physicians even in normal times, is at present one of the most serious and difficult problems confronting the medical profession.

Because of unfavorable business conditions, many accounts on the physician's books, which in normal times would be rated as triple A, are now of questionable value. How to go about liquidating his book accounts is a puzzling question for every physician. Naturally, the physician does not feel justified in refusing his services when life and health are at stake. For this reason, he cannot be as cautious as other business and professional men in extending credit to the public.

Another difficulty which presents itself is the fact that the income from the practice of medicine does not involve the transfer of a tangible material commodity. The physician, of course, cannot secure a lien on the human body and it is not customary for him to accept a retainer fee at the commencement of his services.

Physicians are constantly being solicited by representatives of collection agencies, adjustment companies, service bureaus, etc., which offer services for the collection of delinquent accounts or bookkeeping and accounting systems.

At present, solicitors for many such firms are unusually active in Ohio. Some of these companies, no doubt, are reliable and ethical. Many of them are not. Obviously, the physician is unable to discriminate between good and bad agencies unless he investigates carefully the reputation of each.

It always has been found desirable from the standpoint of the physician, in case he finds it necessary to engage collection and adjustment agencies, to employ, if at all possible, local firms, operated by persons with whom the physician is personally acquainted; whose reputation for honest and efficient service is well known, and about whom information may be easily obtained.

Within the past few months, it has been reported that several solicitors for collection and adjustment agencies, and insurance companies, in calling on physicians, have implied that their companies have the approval of the Ohio State Medical Association or the State Medical Board.

The State Association and the State Medical Board are in no way connected with any collection agency or insurance company and have no agents soliciting business from physicians. Neither has ever endorsed any particular company selling services or products to physicians and neither has authorized solicitors and salesmen contacting the medical profession to quote them to physicians.

Use of the name of the State Association or State Medical Board by solicitors and salesmen should be a warning to the physician and he should refuse to deal with them.

The Headquarters Office of the State Association should be kept informed of questionable and suspicious activities of collection agencies, insurance firms, etc. Members of the State Association in investigating the reputation of such firms should keep in touch with the State Headquarters Office which has collected data and information on some of these firms and may be in a position to advise the physician how to obtain authentic information regarding others.

In the April issue of the *Bulletin of the American Medical Association*, Dr. R. G. Leland, director of the Bureau of Medical Economics of the American Medical Association, discussed in detail some of the collection problems confronting the medical profession. Although Dr. Leland reviewed such technical questions as the book value of accounts, deterioration of accounts, preserving account values, billing patients, follow-up letters, etc., a large part of his discussion, and that which is of primary importance to all physicians, is devoted to an analysis of collection agencies and some of the methods used by third parties in the collection of medical fees.

Dr. Leland's review is of special importance to Ohio physicians at present because of the vigorous campaign being staged in Ohio by salesmen for collection agencies.

Dr. Leland believes that the collection of medical fees cannot be accomplished by any uniform plan or universally adopted single method but that the individual physician must determine for himself the extent to which collection methods are necessary to encourage the payments of his overdue accounts receivable.

"The choice of a third party for collection usually causes most trouble to the physician," he pointed out.

"He finds himself confronted with a wide variety of such agencies. If he has not already had unhappy experience with some of these himself, he may have heard of such experiences on the part of other physicians."

Dr. Leland broadly classifies collection agencies as (1) nation-wide and (2) local.

"It is a good general rule," he declared, "to beware of the 'nation-wide' type, but like all generalities this has some exceptions. Not all 'nation-wide' agencies are 'gyps' but many of the 'gyps' are nation-wide. The crooked agency needs the whole nation in which to work, because it cannot soon work the same territory a second time. Moreover, it usually employs high pressure salesmen, who work fast and cover a lot of territory.

Therefore, when approached by a salesman from such a 'nation-wide' agency, the physician should investigate carefully before giving him any accounts."

A more specific classification for collection agencies, overlapping somewhat the first classification, is (1) the "contract" and (2) "no-contract" agencies, according to Dr. Leland.

"The local agency often does not have a contract, although there are exceptions," he pointed out. "The 'nation-wide' agency almost always has a contract, and if it does, this doubles the need for wariness on the part of the physician. The best class of agencies almost never use contracts, and often make it a point of business ethics not to have one, except on the request of the client. * * * In a questionnaire sent to collection agencies by the American Medical Association there was included a request for copies of their contracts. The best established and the old reliable institutions almost invariably replies 'we have no contract', and some manifestly resented the question as implying unethical practices.

"Contracts never offer protection to the physician and the honest agency needs no contract to protect himself. Agencies using a contract claim that it is necessary to prevent the withdrawal of accounts on which work has been done. If the work done by the agency is of a nature which the client approves and which he understood would be done when he turned over his accounts, he will not withdraw them. If circumstances should arise in the physician's relations with his patients which make it advisable to withdraw accounts, any honest agency will be glad to grant the physician's request. On the other hand, withdrawal is the only effective check on disreputable collection methods. But, if the agency has really done any work on an account which is withdrawn, it has a legal claim which can be enforced for the payment of such services. To enforce such a claim, however, the agency must prove that the work was done and this is something which agencies working on tricky contracts may find difficult to show."

Dr. Leland cited the following "tricky" contract as a sample of some of the forms now offered to physicians by unreliable collection agencies:

In consideration of services to be rendered, the undersigned hereby assigns to the ..... for collection, the legally due claims listed herewith on the following terms and conditions, namely, a docket fee of fifty cents, to be paid out of first collections; all accounts collected, settled, withdrawn or ordered dropped during the process of collection, 50 per cent of the first $100 and 15 per cent thereafter, except on claims that are outlawed, collected on installment, or by our legal department, whereon the charges will be 50 per cent; said commissions to be paid as collections are made, whether payments are made to the above corporation or the undersigned, and the latter agrees to report promptly all payments and immediately remit all money due said corporation as per above schedule to their office at ..... Failure to furnish evidence of indebtedness on request will be considered as instructions to drop. Other than above NO COMMISSION WILL BE CHARGED ON ANY CLAIM UNLESS COLLECTION IS MADE THEREON. No solicitor has authority to alter this agreement, designate method of collection, or accept money from any debtor or client. *This agreement covers all additional claims listed by the undersigned within one year from date thereof.*

"The physician who signs such a contract and turns over his accounts may wait in vain for any report of money collected by the agency (it will be noted there is no clause promising such reports); he may receive bills from the agency for fees and commissions it claims are due and payable, and he may find his patients aroused to bitter feelings toward him by the insulting letters and threats sent them by the agency," Dr. Leland explained.

"If he protests and finally demands return of the accounts, he may receive a letter from an attorney explaining just what the contract which he signed demands from him but never pointing out any privileges guaranteed to the physician. The physician may then discover that in assigning his accounts he gave the agency a power of attorney to handle them as it wished; that he pledged to pay fifty cents 'docket fee' for every account; that he was to pay 50 per cent on the first $100 collected and on all accounts 'outlawed, collected on installments, or by our legal department'; that 'failure to furnish evidence of indebtedness on request' (impossible when the agency judges the evidence) will be considered as instructions to 'drop' and thereby entitle the agency to 50 per cent commission to be paid by the physician whether any collection is made or not, and that all the fine promises made by the solicitor are repudiated by the wording of the contract.

"There is little probability that the physician will get satisfactory results under such a contract. On the contrary, he will not only be faced with the prospect of constantly owing the agency, but he will also be paying the agency for the privilege of losing his accounts and his reputation among his patients. It should be obvious, then, that no physician should ever sign a collection contract. * * * It is usually safe to infer that contract of the type shown here, which requires fortification of so many clauses drawn expressly for the sole benefit of the agent or company, is likely to produce unpleasant results for both patients and physicians. It is imperative, therefore, that before signing a document physicians should understand fully the nature and meaning of every part and clause."

Dr. Leland pointed out that the personal visit method of collection is far more effective than the contact by mail method, although more costly. He warned, however, that while many solicitors of "nation-wide" agencies promise to remain in the locality and make personal collections, it is difficult to find evidence that such practices are the rule.

Companies offering systems or sets of follow-up collection letters, warnings, stickers, etc., for a lump sum should be carefully investigated, as well as their literature, Dr. Leland warned, point-

ing out that a criticism that applies to many such systems is the absence of tact and real collecting skill in writing the letters which are apt to be too harsh and abusive to produce good results; on the contrary, often losing for the physician more accounts than he collects.

"Some forms of collection organizations capitalize on the publicity given by the company to poor debtors, through paid advertisements of lists of accounts for sale, "Dr. Leland said. "This indicates that they have studied the psychology of the creditor, to whom they are selling their goods, more closely than that of the debtor. Not only because such methods smack of 'blackmail' and are often illegal, but also because they are ineffective in reaching a large percentage of collectable accounts (and those are the ones in which the physician has a real financial interest), any company offering the use of such methods should be shunned. The very fact that it does offer them suggests that such company probably does not belong to an organization of reliable, ethical agencies, which seeks to prohibit such methods."

Financing companies or corporations are now making a strong appeal for the physicians' business, a typical method of operation consisting of a ten-payment plan by which the physician is given a certain amount of cash immediately on the strength of a judgment note signed by the patient and two co-signers, Dr. Leland stated.

Under the customary procedure of such firms, the physician desiring to borrow money from the company must obtain from patients who are indebted to him a series of judgment notes. The borrowing physician is required by special form of endorsement to become for all practical purposes a co-maker of the note. The lending company scrutinizes the notes submitted to it as collateral for loans. If, in the judgment of the company, a note is first-class, the company will lend to the physician 85 per cent of its face value. If the company fails to collect the note, it returns it to the physician and collects from him the amount lent by the company, plus interest at the rate of 6 per cent per annum. If the patient pays the notes, interest on their face value is paid by the patient. There is nothing to show that all interest collected by the company from the patient is not retained by the company whether it has made a loan or not. When the notes are paid by and returned to the patient who made them, the doctor is discharged of the debt to the company.

Commenting on this method, Dr. Leland said:

"The company seems to assume absolutely no risk, except such as is incident to evaluating the financial hazards arising out of the moral and financial standing of the physician, for he in the end is responsible to the company, not only for the loan that he has received, but for the full face value of the notes deposited with the company for collection. In making collection, the company seems to render no service whatever other than furnished by an ordinary collection agency. In the way of loans, the company seems to follow the practice required in the loan business generally, or requiring a physician to give adequate security for any loan he may receive and of taking into consideration the moral and financial hazards of the physician himself as determined by the physician's own character and business standing. There is, however, this distinction: In an ordinary loan, the borrower becomes responsible only for the amount of the loan, while according to the methods used by many finance companies, if the record has been correctly interpreted, the borrower becomes responsible not only for the amount that he borrows but also for the difference between the amount borrowed and the face value of the note. The borrower does not often have the use of the full amount of the loan since interest is deducted in advance.

"Demands by physicians for notes from their patients, supplemented by efforts of collection agents to enforce payment of such notes, seems hardly calculated to increase the respect and confidence that a patient may have in his physician. Nothing appears in the record to show that a physician would have substantially less bookkeeping under the finance system. * * * The fact that the physician is compelled to pay 15 per cent for the collection of what the company itself rates as gilt-edged notes seems to be unreasonable."

Concluding his discussion, Dr. Leland stressed the fact that "physicians cannot be too cautious in the selection of collection methods and agencies".

"The choice," he said, "must be made between modern ethical business practices which retain professional respect and unfair, unethical, humiliating and almost illegal means which destroy confidence and good will."

Dr. Leland is of the opinion that the exercise of a few simple precautions on the part of the physician or his secretary when the debt is incurred; the mailing of statements regularly; the use of follow-up statements and letters, and especially efforts to communicate personally with the debtor regarding a settlement, will do much to decrease the number of accounts which eventually may have to be placed into the hands of a collecting agency; produce better financial results, and maintain better relationship between the physician and his patients.

Annual Graduate Fortnight of the New York Academy of Medicine will be held October 17 to 28 inclusive at the Academy building, 2 East 103rd Street, New York City.

Legal Interpretation of Schools at Tuberculosis Hospitals, Points on Malpractice, Ownership of X-ray and Other Medical Questions

Interpretation of the statutes relating to the establishment, maintenance and supervision of a school at a county tuberculosis hospital was made recently in an opinion by Attorney General Gilbert Bettman upon the request of the prosecuting attorney of Clark County.

The following essential points are found in the syllabus of the opinion:

1. A school maintained at a county tuberculosis hospital as authorized by Section 7644-2, General Code, should be supervised, so far as the arrangement of school curriculum, general organization of the school, grading of public, extension of school credits, recommendation of teachers, textbooks and necessary equipment are concerned, by the county superintendent of schools. The administration of the school in other respects than its academic features should be under the supervision of the superintendent of the hospital. The said county superintendent of schools and the superintendent of the hospital should, so far as possible, cooperate in the management and maintenance of the schools.
2. It is the duty of the trustees of the hospital to employ necessary teachers and purchase necessary textbooks, equipment and supplies for the school, upon the recommendation, so far as is consistent with good management, of the county superintendent of schools.
3. A teacher in a school maintained at a tuberculosis hospital by authority of Section 7644-2, General Code, does not become a member of the State Teachers' Retirement system, unless the trustees of said institution accept the requirement and obligations of the law relating to the establishment and maintenance of the State Teachers' Retirement system or the teacher, himself, is a contributor to said system.
4. The provisions of Section 7600, General Code, with reference to the minimum salary to be paid to school teachers have no application to the payment of salaries to teachers in a school maintained at a tuberculosis hospital established and maintained by authority of Section 7644-2, General Code.

* * *

A recent decision of the Supreme Court of the State of Washington in a case bearing on the open treatment of fractures (Prather vs. Downs) presents an interesting argument on an important surgical question.

The following excerpts from the court's decision should be of interest to all physicians, inasmuch as the court's views are in effect a warning to physicians generally to resort to radical therapy only after more conservative methods have been used unsuccessfully:

"The verdict in a malpractice action should be sustained," the court stated, "where it appeared that an operation was performed in order to set a fractured femur without first attempting to secure a union by the use of some generally used extension process.

"The evidence is ample to warrant the conclusion that the opening of the flesh, the injury thereto being wholly internal, and the insertion of a 'Lane plate' with a view of holding the ends of a broken bone in apposition and alignment, is a method of last resort, so recognized by the profession generally, because of the great danger of infection following such method of treatment.

"In the present case there is ample evidence to warrant the jury in finding the appellant guilty of negligence in resorting to an open operation for the purpose of effecting a union of a fractured bone without first exhausting such well-known and universally proved methods as manipulation, traction and extension processes."

* * *

The question whether the roentgenograms of a hospital patient belong to the patient or to the hospital has been answered by a court for the first time, so far as is known, in the case of Hurley Hospital vs. Gage, decided on appeal by the circuit court for the county of Genesee, Michigan, according to a review of the case in the November 21, 1931, issue of *The Journal of the American Medical Association.*

As reviewed in the *Journal A. M. A.*, the patient had been roentgenographed in the roentgenographic department of the Hurley Hospital in Flint. The usual charge for the service was included in the patient's bill. He made a payment on account but refused to pay the charge for roentgenographic service unless the roentgenograms were delivered to him. The hospital refused to deliver them and sued the patient for the balance due. In the justice's court where the suit was instituted, judgment was given against the hospital. The hospital, however, because of the principle involved, appealed to the circuit court of Genesee County. At the hearing on the appeal, no one appeared on behalf of the patient and the case was heard and judgment rendered without the submission of evidence or argument by him. In giving judgment, the court pointed out that the hospital sold and patients paid for, not the material that went into roentgenograms, but knowledge and experience. The protection of the hospital might depend largely on the proper preservation of the roentgenograms and, said the court, the films should remain with the hospital. Judgment was given against the patient for the balance due on his bill, covering the amount charged by the hospital for the roentgenograms.

* * *

A dental hygienist (one who cleans teeth) may practice only under the supervision of a licensed dentist, and he may work only in a dental office,

public or private school, hospital, dispensary, or public institution, according to an opinion by Attorney General Bettman given to the Ohio State Dental Board.

Mr. Bettman's opinion was rendered in answer to the Board's inquiry concerning notices sent out by a licensed and registered dentist to the effect that he employed a dental hygienist who worked in a location other than the dentist's office.

The attorney general also held that while such hygienist must work under the supervision of a dentist, this does not necessarily mean that the work must be carried on in the same room in which the dentist conducts his dental practice, and that the requirement of the law is satisfied when the dentist inspects the work of the dental hygienist in such places as he or she is legally entitled to practice.

* * *

Albert Stump, legal counsel for the Indiana State Medical Association, has replied in answer to an inquiry of a member of that association, that in his opinion a physician who fills his own prescriptions and dispenses medicine only as incident to his professional services, is not operating a store and therefore would not be required to pay the store license fee provided for in the Indiana Chain Store License Act.

Public Health Nursing Status in Ohio

An interesting statistical report on the status of public health nursing services in Ohio as of January 1, 1932, was published in a recent issue of the *Ohio Health News*. The article in part follows:

Following is a tabulation from official records showing the status of public health nursing services in Ohio, with the nature of their supporting agencies, as of January 1, 1932. It shows a total of 1036 public health nurses in service, an actual, even though small, gain as compared with 977 at the beginning of 1931. Gains in the field were more than enough to offset the loss of three supervising nurses in the State Department of Health.

The total of 1036 nurses is distributed as follows: City, 836; county, 168; village, 16; State departments, 16. Details of the field compilation follow:

City — *Supporting Agency*	*Number of Nurses*
Board of Health	283
Board of Health and Public Health League	1
Board of Health and Board of Education	1
Board of Health and Federated Clubs	1
Board of Health and Visiting Nurse Association	74
Board of Health, P. H. L., and Red Cross	6
Board of Health, Federated Clubs, and P. H. L.	1
Board of Education	153
Board of Education and Red Cross	1
Visiting Nurse Association	193
Metropolitan Life Insurance Company	36
Civic Association	5
Community Fund	33
Public Health League	11
Red Cross	6
Federated Clubs	2
Western Reserve University	12
Maternity Hospital	13
County Commissioners	1
Other	3
Total	836
County	
Board of Health	112
Board of Health and Public Health League	1
County Board of Health and City Board of Health	3
County Board of Health and City Bd. of Education	1
Board of Health and Red Cross	1
Board of Education	2
U. S. Public Health Service	19
Public Health League	7
County Commissioners	10
Commonwealth Fund	6
Red Cross	4
County Commissioners and Public Health League	3
Total	168
Village	
Board of Education	6
Red Cross	1
Mothers' Club	1
Community Fund	4
Visiting Nurse Association	1
Other	3
Total	16

County Changes

Gain in Personnel

Adams County—1 nurse—U. S. Public Health Service.
Allen County—1 nurse—County Board of Health.
Darke County—1 nurse—County Board of Health.
Hamilton County—1 nurse—Red Cross.
Ross County—1 nurse—U. S. Public Health Service.

Gain in Services

Brown County—1 nurse—U. S. Public Health Service.
Gallia County—1 nurse—U. S. Public Health Service.
Marion County—1 nurse—Public Health League.
Meigs County—1 nurse—U. S. Public Health Service.
Stark County—1 nurse—Public Health League.

Loss in Services

Belmont County—1 nurse—P. H. L. and County Sanatorium.
Morrow County—1 nurse—County Board of Health and Red Cross.
Putnam County—1 nurse—Public Health League.

Change in Financing

Franklin County—County Commissioners nurse taken over by the District Nursing Asociation, Columbus.
Union County—Public Health League nurse taken over by the County Board of Health.
Highland County—Public Health League nurse taken over by the U. S. Public Health Service.
Muskingum County—County Commissioners nurse taken over by the U. S. Public Health Service.

City Changes

Gain in Personnel

Hamilton—1 nurse—Public Health League.
Springfield—1 nurse—Board of Health.
Mansfield—2 nurses—Visiting Nurse Association.

Loss in Personnel

Middletown—1 nurse—Civic Association.
Sandusky—1 nurse—Board of Education.
Sidney—1 nurse—Board of Health.
Alliance—1 nurse—Board of Education.
Barberton—1 nurse—Red Cross.

Gain in Services

Bexley—1 nurse—Board of Health.
Troy—1 nurse—Metropolitan Life Insurance Company.
Oakwood—1 nurse—Board of Health and Board of Education.

Loss in Services

Blanchester—1 nurse—Board of Education.
East Liverpool—1 nurse—Board of Education.
Portsmouth—1 nurse—Bureau of Community Service.
Marietta—1 nurse—Board of Education.

State Department of Health

Loss in Personenl

3 nurses.

Ohio Eclectics on National Program

The following Ohio physicians took part in the annual meeting of the National Eclectic Medical Association, held at Little Rock, Ark., June 21-24:

Dr. C. R. Campbell, Newton, president of the association; Dr. T. D. Hollingsworth, Akron; Dr. W. L. Laport, Cincinnati; Dr. Cloyce Wilson, Cincinnati; Dr. Byron H. Nellans, Cincinnati; Dr. George M. Hite, Toledo; Dr. C. W. Holtzmuller, Farmersville; Dr. W. N. Mundy, Forest; Dr. M. E. Bowles, Cincinnati; Dr. E. B. Shewman, Cincinnati; Dr. S. W. Mattox, Marion; Dr. John L. Payne, Cincinnati; Dr. D. N. Cavenaugh, Reading; Dr. F. L. Thomas, Marion; Dr. E. M. Wright, Coshocton; Dr. C. G. Smith, Marion; Dr. E. G. Zeumer, Cincinnati; Dr. H. E. Dwire, Bucyrus; Dr. J. B. Alexander, Cincinnati; Dr. J. S. Hagen, Cincinnati; Dr. C. R. Deeds, Cincinnati; Dr. A. Harry Crum, Cincinnati; Dr. John Uri Lloyd, Cincinnati; Dr. J. H. McLachlin, Cincinnati; Dr. Arnold Ganzel, Cincinnati; Dr. Morris Marks, Cincinnati; Dr. C. S. Amidon, Cincinnati; Dr. B. M. Warne, Cincinnati; Dr. A. H. Dutton, Cincinnati; Dr. Carroll Behymer, Cincinnati; Dr. C. W. Beaman, Cincinnati; Dr. W. P. Brown, Wyoming; Dr. C. A. Price, Cincinnati; Dr. B. M. Alleman, Cincinnati; Dr. Robert B. Curl, Toledo; Dr. H. G. Brown, Cincinnati; Dr. R. H. Curnayn, Cincinnati; Dr. E. V. Stewart, Cincinnati; Dr. J. S. Niederkorn, Versailles; Dr. W. W. Dangeleisen, Cleveland.

List of Questions Asked Large Class of Applicants at June Examinations Held by State Medical Board

One of the largest classes ever to appear before the State Medical Board, numbering 367, took the semi-annual examinations given by the Board in Columbus, June 7, 8, 9 and 10.

Two hundred and thirty-seven took the examinations for licenses to practice medicine and surgery, 74 of this number being graduates of the College of Medicine, Ohio State University; 60 of the College of Medicine, University of Cincinnati; 56 of the School of Medicine, Western Reserve University, and 47 from medical schools of other states.

The following took examinations for licenses in their respective fields of practice: 26 osteopaths, 48 chiropodists, 15 chiropractors, 6 mechanotherapists, 6 electro-therapists, 3 cosmetic therapists, and 26 masseurs.

The grades of the applicants will be announced at the next meeting of the Board, to be held on July 12.

The written examinations were given in the new Physical Education Building on the Ohio State University campus and the practical examinations at St. Francis Hospital.

Questions asked the medical and surgical applicants in the written examinations follow:

ANATOMY

1. Give the origin of the spinal nerves.
   How many pairs are there and through what foramina do they pass?
2. Locate the inferior turbinate bones.
   Name the bones with which they articulate.
3. What is the origin, insertion, action and nerve supply of the flexor longus pollicis muscle?
4. Describe the stomach.
   Name the coverings, glands, nerve and blood supply.
5. Mention the ligaments found in the acromio-clavicular articulation. Classify this articulation.

PHYSIOLOGY

1. Why is clotting delayed when blood is drawn into (a) paraffined vessels (b) solution of sodium citrate?
2. What are the physiological consequences of thyroid deficiency?
3. Compare the situation in adults and infants with respect to (a) the acidity of the gastric contents (b) the mechanism of the gastric digestion of proteins.
4. Define or describe concisely the concepts covered by the following: (a) axone reflex (b) hemostasis (c) Hormone (d) pulse pressure (e) aphasia (f) blood types.
5. Outline what you know about the functions of the adrenal medulla.
6. What changes occur in the composition of the urine with respect to the following constituents during the first days fasting (a) total nitrogen (b) chloride (c) acetone bodies?
7. What changes in the body may be brought about by a deficient supply of calcium in the food?
8. What is the present conception of the control of the activity and function of the gall bladder?
9. Discuss briefly the physiological involvement of the central nervous system in the act of walking.
10. Discuss the phenomena of summation in nerve and muscle.

DIAGNOSIS

1. Give differential diagnosis between woody phlegmon, actinomycosis and sarcoma of the glands of the neck.
2. What findings would lead you to a diagnosis of acute pericarditis with effusion?
3. Discuss briefly—appendicitis in the young and in the aged. Also, what bearing would the location of the appendix (such as post-cecal, pelvic or undescended appendix) have upon the temperature, pain, rigidity and leukocyte count?
4. Name the causes for absence of menstruation.
5. Differentiate between the following ulcers of the leg; varicose, tuberculous, syphilitic.
6. Discuss the characteristics of the spinal fluid in the following:
   Tuberclous meningitis, epidemic meningitis, cord tumor with compression.
7. Differentiate between gastric and duodenal ulcer.
8. State the probable causes of post operative pneumonia. Give diagnosis. In what part of the lungs does it usually begin?
9. Give causes of optic edema. Differentiate between them.
10. Diagnose a case of semi-lunar cartilage dislocation in the outer side of the knee joint.

CHEMISTRY

1. Name and give formulae of the iron salts used in medicine.
2. What is the difference between fermentation and putrefaction? What conditions are necessary to produce each?
3. How would you conduct an autopsy in a case suspected of arsenic poisoning?
4. What are the chemical constituents of biliary and urinary calculi?
5. What is the chemical name and formula of Iodoform?

MATERIA MEDICA

1. Define an antiseptic agent. Mention two important intestinal antiseptics, the diseases in which they are indicated and explain how they are used.
2. Give the average dose of tincture and fluid extract of aconite, tincture and fluid extract of digitalis, camphorated tincture of opium and tincture of nux vomica.
3. Give the therapeutic uses and dose of nitroglycerine.
4. Name three nerve sedatives. Give physiologic action and dose of each.
5. How do the simple bitters aid digestion?
   Mention two and give dose.
6. Purgatives—name two saline and two cholagogue with dose of each.
7. Name three new remedies with use and dose of each.
8. Write a prescription for case of influenza.
9. Give origin of podophyllin, its action and dose.
10. Pituitrin—from what is it derived? Give its dose, manner of administration, field of employment and physiologic effect.

MATERIA MEDICA
(Homeopathic)

1. Give five characteristic symptoms of Pulsatilla.
2. What are the chest symptoms of Stannum-Met?
3. Name twelve remedies commonly indicated in constipation.
4. Give three reliable symptoms for Crategus in heart disease.
5. What are the symptoms of Causticum upon the respiratory organs?
6. Give ear symptoms of Capsicum.
7. Indications for Hypscyamus in the typhoid state.
8. From what is Lachesis derived?
9. What changes are made in the glands by Mercury?
10. What is the action of Hamamelis upon the capillaries?

BACTERIOLOGY, PATHOLOGY AND HYGIENE

1. Outline the methods of immunizing children against diphtheria. What is the best method and to what degree is it successful?
2. What is the significance when the blood chemistry examination shows (a) a non-protein nitrogen of 60? (b) blood sugar 200 mg. per 100 cc. of blood?
3. What are the indications of hasal metabolism tests? (a) Increased rates (b) Decreased rates.
4. What are the dangers to health from too highly re-

fining of food products such as white flour, salt, polished rice, etc.?

5. For what purpose is chlorine added to drinking water supplies?

6. Discuss briefly the advantages and disadvantages of (a) pasteurized milk (b) raw milk.

7. What pathologic conditions may follow in that organ as a result of a dropped or floating kidney?

8. What changes take place in (a) the bone marrow (b) the spinal cord in pernicious anemia?

9. What are the distinguishing pathologic features of Hodgkin's disease?

10. What dangers to workers arise in such industries as rubber, paint, shell or stone grinders and luminous watch makers?

PRACTICE

1. How would you make (a) a presumptive diagnosis of epidemic anterior poliomyelitis? (b) a positive diagnosis? Outline treatment of early stage.

2. What are some of the dangers of unsupervised "reducing" measures (a) diet (b) drug and other measures?

3. A patient 30 years of age with a history of "stomach trouble" for a year or more, vomits a large quantity of blood; what would you suspect and give immediate treatment. Outline later procedures for diagnosis and treatment.

4. A man 55 years of age (apparently in good health) after a hearty lunch engages in strenuous exercise; he complains of severe epigastric distress, belching and other symptoms which he describes as indigestion; he suddenly collapses. What would you suspect and what would be your treatment?

5. A man in active business life is rejected for life insurance because of blood pressure reading of 180/110 and applies to you for treatment. What measures would you advise?

6. Give the main symptoms of hyperthyroidism and outline treatment (a) mild degree, young patient and general diffuse enlargement of thyroid (b) more pronounced symptoms, patient past thirty and thyroid nodular.

7. A child ill with measles develops a sharp increase of fever, cough is severe, respirations increased in frequency; what would you suspect? Outline confirmatory physical findings and treatment.

8. Give three conditions which may be associated with general convulsions in the adult and how to distinguish between them.

9. A young individual has a history of general asthenia, rather slowly accumulating fluid in abdomen, no enlarged organs felt on palpation, slight diffuse tenderness, temperature 99.2°; what would you suspect, how establish diagnosis and give treatment?

10. A patient is seized with severe colicky pains in right side; how would you differentiate between right side renal calculus and stone in common bile duct? Give treatment of the condition of which you establish the diagnosis.

OBSTETRICS

1. Describe in detail the management of a posterior presentation—either right or left.

2. What have you to say about high forceps operations? When are they indicated? Give possible evil results.

3. Give symptoms and management of (a) retained (b) adherent placenta.

4. What is rotation and version? How is each performed?

5. Name the most important vaginal diagnostic agencies or factors in a vertex and breech presentation.

SURGERY

1. Discuss fracture of pelvis.

2. Give the differential diagnosis of ulcer of the tongue.

3. Discuss the surgical anatomy of the cervical lymphatics.

4. Discuss the treatment of extensive burns.

5. Discuss pulmonary embolism as a surgical complication.

6. What are the chief causes of mortality after operations for the following conditions:

1. Hypertrophied prostate gland
2. Exophthalmic goiter
3. Suppurative appendicitis
4. Inguinal hernia in the aged.

7. A patient enters the hospital as an emergency—he is unconscious, X-Ray shows skull fracture. Give the cardinal signs of increased intercranial pressure and discuss the management of brain injuries.

8. Discuss the management of a spiral fracture in the mid third of the femur.

9. You are called to see a patient following an automobile accident—he complains of severe abdominal pain, there is rigidity and tenderness in the upper abdomen, the pulse rate is increasing, there is air hunger; how would you proceed in the diagnosis and management of this patient?

10. Diagnose a case of acute intestinal obstruction.

SPECIALTIES

1. Mrs. G., aged 56, has the following symptoms: gradual diminishing visual acuity, narrowing of visual field, cupped disk, slightly increased tension—give diagnosis and treatment.

2. Name the different forms of ametropia.

3. Discuss electrocoagulation of the tonsil.

4. Give causative agent of the following: yaws, favus, blastomycosis, leprosy, Vincent's angina, actinomycosis, chancroid, pityriasis rosea, scabies, syphilis.

5. Describe a normal ocular fundus.

Ohio Public Health Association Reelects Officers

At the annual meeting of the Ohio Public Health Association in Columbus, May 5, the following officers were re-elected: President, Dr. H. Kennon Dunham, Cincinnati; secretary, Dr. J. W. Wilce, Columbus; treasurer, Thomas H. Dickson, Columbus; counsel, John W. Bricker, Columbus; auditor, Charles L. LaMonte, Columbus; executive secretary, R. G. Paterson.

Other officers elected were: First vice president, Mrs. S. C. Frantz, DeGraff; second vice president, Mrs. C. H. Jones, Jackson; members of executive committee, Dr. F. C. Anderson, Mt. Vernon; Dr. F. G. Barr, Dayton; W. H. Dittoe, Youngstown; J. E. Hagerty, Columbus; Dr. E. R. Hiatt, Troy; Dr. Maurice Loebell, Zanesville, and Dr. Foster Myers, Toledo; members of the board of trustees, Mrs. Marvin Homer, Canton; Dr. G. L. Moore, Girard; Mrs. W. J. Alexander, Jr., Steubenville; Dr. Maurice Loebell, Zanesville; Mrs. S. B. McClain, Bellaire; Mrs. Robert Smith, Swanton; Mrs. C. J. Devore, Sherwood; A. D. Hufford, Bremen; Dr. E. M. Wright, Coshocton; Mrs. L. W. Naus, Upper Sandusky; Gorden Davies, Akron; Mrs. C. H. Jones, Jackson; Miss Anna B. Johnson, Springfield; Mrs. Latta Crow, Marion; Mrs. William F. Marting, Ironton; Mrs. Reed Wilson, Pleasant City; Mrs. E. W. Burkley, Ravenna; Dr. F. C. Anderson, Mt. Vernon; Dr. Robert Bishop, Jr., Cleveland; Perry P. Denune, Columbus; Dr. E. R. Hiatt, Troy, and Mrs. S. C. Frantz, DeGraff.

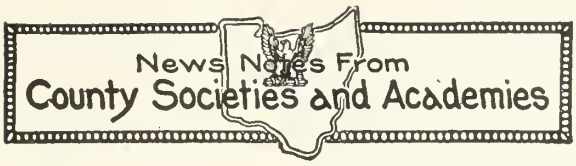
New Books Received

Pain in the Pleura Pericardium and Peritoneum—A Clinical Study, by Joseph A. Capps, M.D., professor of clinical medicine, University of Chicago, with the collaboration of George H. Coleman, M.D., assistant professor of medicine, Rush Medical College. Introduction by Anton J. Carlson, M.D., chairman of the department of physiology, University of Chicago. MacMillan Company, publishers, 60 Fifth Avenue, New York City. Price, $3.00.

The Expectant Mother's Handbook, by Frederick C. Irving, M.D., professor of obstetrics, Harvard Medical School; Houghton, Mifflin Company, publishers, 2 Park Street, Boston; price, $1.75.

St. Elizabeth's, Dayton, On Approved List

St. Elizabeth's Hospital, Dayton, is on the list of Ohio hospitals approved by the Council on Medical Education and Hospitals of the American Medical Association for intern training. It was inadvertently omitted from the list of approved hospitals carried in the annual report of the Committee on Medical Education and Hospitals of the State Association (May, 1932, issue of *The Journal)* due to an error in copying the list from the last report of the A.M.A. council.



First District

ACADEMY OF MEDICINE OF CINCINNATI

(H. H. Shook, M.D., Secretary)

May 26—Annual election of officers for the annual term beginning in September, 1932. The following were elected: President-elect, Dr. Samuel Iglauer; secretary, Dr. George B. Topmoeller; treasurer, Dr. E. O. Swartz; legislative committeeman, Dr. Robert B. Cofield; medical defense committeeman, Dr. Samuel Zielonka; delegates to State Association annual meeting, Drs. E. O. Smith, Henry B. Frieberg, J. V. Greenebaum, Otto Seibert, Louis Feid, Jr., and Charles E. Kiely; alternates, Drs. Ralph W. Good, R. L. Crudgington, Albert Brown, E. O. Swartz, Samuel Zielonka, and Eslie Asbury. Dr. Parke G. Smith, elected president-elect at the May, 1931, meeting will take office at the September meeting.

June 8—A reception sponsored by the Council of the Academy and the Board of Directors of the Cincinnati Dental Society, officially opened the new headquarters of the Academy and the dental society on the 17th floor of the Union Central Life Building. The program consisted of an invocation address by Rev. Jesse M. Halsey and addresses by Dr. L. Howard Schriver, past president of the Academy; E. Russell Cumley, D.D.S., president of the Cincinnati Dental Society; W. Howard Cox, president of the Union Central Life Insurance Company, and Hon. Russell Wilson, mayor of Cincinnati. Dr. William M. Doughty, president of the Academy, presided. A buffet supper was served following the program.

Clermont County Medical Society met in the school auditorium, Owensville, on May 18. Following the business session, a paper on "Management of the Diabetic Patient" was read by Dr. Oscar Berghausen. Discussion of case reports concluded the program.—Allan B. Rapp, M.D., secretary.

Clinton County Medical Society was addressed by Dr. Ben R. McClellan, Xenia, at its regular meeting June 7 at the General Denver Hotel, Wilmington. Dr. McClellan spoke on "The Costs of Medical Care".—News Clipping.

Second District

Champaign County Medical Society held a business meeting June 9 at the Douglas Hotel, Urbana.—Bulletin.

Clark County Medical Society held a luncheon meeting May 11 at the Hotel Bancroft, Springfield. Dr. R. S. Fidler presented a paper on "Critical Significance of Jaundice". The subject was discussed by Dr. F. P. Anzinger and Dr. H. A. McKnight.

The society on May 25 was addressed by Dr. Milton B. Cohen, Cleveland, on "The Relation of Allergy to the Problem of the Practicing Physician".

The annual joint picnic of the Clark County Medical Society and the Clark County Dental Society was held June 8 at the Springfield Country Club. The medical society committee which aided in arranging the program for the outing consisted of Drs. G. C. Ullery, J. H. Riley and J. H. Rinehart.—Edward C. Nehls, M.D., Secretary.

Greene County Medical Society met in regular session June 2 with Dr. H. A. McKnight, Springfield, as the guest essayist. Dr. McKnight read a paper on "The Surgical Abdomen". The outstanding surgical conditions of the abdomen were fully described and the treatment outlined. The society adjourned following a luncheon at the Iron Lantern.—H. C. Schick, M.D., Secretary.

Miami and Shelby County Medical Societies held a joint all-day meeting on June 2 at the Sidney Country Club. A golf tournament was held in the morning. Following luncheon, Dr. Roy Arn, Springfield, addressed the societies on "Fractures of the Skull". A dinner and social hour concluded the outing.

Montgomery County Medical Society held its annual meeting and election of officers June 3 at the Miami Valley Golf Club. The following officers were elected: President, Dr. A. F. Kuhl; first vice president, Dr. Wallace E. Prugh; second vice president, Dr. C. R. Weis; delegates to annual meeting of the State Asociation, Dr. A. O. Peters, three years; Dr. A. W. Carley, two years; Dr. C. C. McLean, one year; alternates, Dr. B. F. Suffron, Dr. H. H. Hatcher, and Dr. W. B. Bryant; censor, Dr. Henry Snow; legislative and medical defense committeeman, Dr. Webster S. Smith. The guest speaker of the evening was Dr. Irving Cutter, dean of the School of Medicine, Northwestern University. His subject was "The Story of Childbed Fever".

The society met in regular session May 20 at the Fidelity Medical Building. The program was on "The Compression Therapy of Pulmonary Tuberculosis". Dr. W. C. Breidenbach presented the medical aspects and Dr. E. R. Arn the surgical aspects.—Bulletin.

Third District

Hancock County Medical Society met in regular session June 1 at the Elks' Home, Findlay. The program was presented by Dr. J. M. Firmin and Dr. D. C. Hughes. Dr. Firmin spoke on "Injection Treatment of Hemorrhoids", and Dr. Hughes on "Addison's Disease; With a Review of Ten Cases". A general discussion followed both papers.

The May meeting of the society was held on May 12 at the Red Robin Tea Room. Following a dinner and business session, the meeting was turned over to two veterans of the society, Dr. J. C. Tritch and Dr. M. A. Darbyshire, who told some interesting events of medical practice of 50 or more years ago.—H. O. Crosby, M.D., Secretary.

Marion Academy of Medicine held its regular meeting May 10 at White Oaks Farm, the guests of Dr. Carl W. Sawyer. The guest speaker of the evening was Dr. Theodore T. Zuck, assistant professor of anatomy, School of Medicine, Western Reserve University and formerly of Marion. He told of recent experimental studies in the treatment of underdeveloped mental and physical cases. Dr. Sawyer presented a paper on "The Causes of Disease". A number of physicians from surrounding cities and the nursing staff at the Marion City Hospital were guests. Refreshments were served at the conclusion of the meeting.

The June meeting of the Academy was held June 8 at the Marion City Hospital with Dr. Willard Stoner, and Dr. A. J. Skeel, both of Cleveland, as guest speakers. Dr. Stoner presented a paper on "Granulocytopenia" and Dr. Skeel spoke on "Caeserian Section".—Kenneth D. Smith, M.D., Secretary.

Fourth District

ACADEMY OF MEDICINE OF TOLEDO AND LUCAS COUNTY

(A. P. Hancuff, M.D., Secretary)

June 3—General Session, Academy Building. Program: Address, "Doctors and Lawsuits", by Hon. George R. Effler, Toledo attorney.

Ottawa County Medical Society held its regular monthly meeting May 19 at Oak Harbor. Following a business meeting, a roundtable discussion was held.—News Clipping.

Sandusky County Medical Society at its meeting May 26 at the city hall, Findlay, was addressed by Dr. J. C. Boyce on "Blood Pressure".—News Clipping.

Wood County Medical Society met in regular session at the Women's Club, Bowling Green, May 19. The scientific program was furnished by Dr. Frank M. Wiseley, Findlay, who spoke on "Things From the Medical Clinic in Vienna". Dr. Wiseley recently returned from Vienna where he took post-graduate work. The talk was interesting and instructive. Dr. Wiseley also demonstrated two cases to illustrate points in his discussion.—R. N. Whitehead, M.D., Correspondent.

Fifth District

Geauga County Medical Society held its regular monthly meeting May 25 at the home of Dr. W. C. Corey, Chardon. A round-table discussion was held.—News Clipping.

Huron County Medical Society held a well-attended meeting in the community room of the Telephone Building, Norwalk, on May 17. The guest speakers of the evening were Dr. Norris W. Gillette and Dr. A. H. Schade, both of Toledo. Dr. Gillette spoke on "Goiter" and Dr. Schade presented a paper on "Pathology of the Thyroid Gland". Both presentations were illustrated. A general discussion followed the addresses.—B. C. Pilkey, M.D., Secretary.

Lorain County Medical Society held a dinner meeting on May 17 at the Congregational Church, Wellington. Wives of the members were guests. Following a dinner and a business session, at which Dr. S. V. Burley reported on the annual meeting of the State Association at Dayton, an interesting address on "Aviation" was made by Dr. M. B. Cohen, Cleveland.—News Clipping.

Sixth District

Ashland County Medical Society was entertained by the physicians of Loudonville at the Mifflin Inn, Mifflin, on May 13. Following the dinner, a paper on "Nephrosis" was presented by Dr. William Hull, Elyria, and one on "Headache and Its Causes", by Dr. J. T. Fawcett, Elyria. Dr. L. G. Sheets reviewed the recent annual meeting of the State Association at Dayton.—Paul E. Kellogg, M.D., Secretary.

Mahoning County Medical Society at its regular meeting on June 21 at Youngstown was addressed by Dr. C. D. Christie, clinical professor of medicine, School of Medicine, Western Reserve University.—Bulletin.

Portage County Medical Society was entertained on June 2 at the home of Dr. J. T. Norton, Kent. A report on the annual meeting of the State Association at Dayton was presented by Dr. S. U. Sivon. The principal address on the program was made by Dr. Claude B. Norris, Youngstown. Dr. Norris spoke on "The Management of Ordinary Skin Disorders". It was a practical discussion and helpful to the general practitioner, being illustrated by many slides.—E. J. Widdecombe, M.D., Secretary.

Stark County Medical Society met May 25 at the Alliance Country Club. Following a golf tournament in the afternoon, a dinner was served and the society was addressed by Dr. Myron

Metzenbaum and Dr. R. M. McKay, both of Cleveland. Dr. Metzenbaum spoke on "Nasal Reconstruction and Reconstructive Surgery" and Dr. McKay on "Results of Compression Methods of Treatment of Pulmonary Tuberculosis". Arrangements were handled by Dr. W. G. Siddall and Dr. G. L. King, Jr.

The annual picnic of the Stark County Medical Society was held on June 22 at the Brookside Country Club. Luncheon was served at noon, followed by an address by Dr. M. L. Harris, Chicago, former president of the American Medical Association. A golf tournament was held after the program.

Summit County Medical Society met in regular session on June 7 at the Mayflower Hotel, Akron. The program was presented by Dr. G. E. McKean, professor of medicine, Detroit College of Medicine and Surgery. Dr. McKean spoke on "Pneumonia". —Bulletin.

Wayne County Medical Society held a dinner meeting for members and their wives and guests at Orrville on May 10. Following the dinner, the ladies were entertained at the home of Dr. and Mrs. O. P. Ulrich while members of the society held their regular meeting. The program consisted of a written report of the annual meeting of the State Association at Dayton, and a review of the history of the Wayne County Medical Society, both being presented by Dr. R. C. Paul. The history traced the ups and downs of the society and pointed out that at present the society is in a stronger position than it has ever been, both from the standpoint of membership and interest.—R. C. Paul, M.D., Secretary.

Seventh District

Coshocton County Medical Society met in regular session May 26 at the Nurses' Home, Coshocton. Dr. S. B. Kistler was the principal essayist.

The April meeting of the society, held April 28, was addressed by Dr. Harold W. Lear and Dr. W. H. Keenan.—News Clipping.

Jefferson County Medical Society met May 24 at the Steubenville Country Club. Following golf in the afternoon, a dinner was served and in the evening the society was addressed by Dr. Verne A. Dodd and Dr. Philip J. Reel, both of Columbus. Among the guests was Dr. E. B. Shanley, New Philadelphia, councilor of the Seventh District.—News Clipping.

Tuscarawas County Medical Society at its meeting May 12 at Dover heard case reports on agranulocytic angina, presented by Dr. Max Shaweker, Dover, and Dr. A. Lichtblau, Canton. —News Clipping.

Eighth District

Eighth District Medical Association was entertained June 23 at the Rocky Glen Sanatorium, McConnelsville, the guest of H. A. Phillips, superintendent of the institution. The meeting was held under the auspices of the Morgan County Medical Society. A luncheon was served at noon, followed by entertainment and a scientific program.—Bulletin.

Athens County Medical Society at its regular meeting on May 2 at Athens was addressed by Judge Harley Whitcraft, Logan, on "The Physician From the Lawyer's Viewpoint". There was a good attendance. Luncheon was served the members and guests at the Dew Hotel.

At the June meeting of the society, held at Athens, June 6, Dr. A. G. Helmick, Columbus, spoke on "Diarrheal Diseases of Children". Dinner was served at the Presbyterian Church.—News Clipping.

Guernsey County Medical Society held a meeting June 2 at the Romance Restaurant, Cambridge. Dr. Fred Fletcher, Columbus, was the guest speaker, talking on "Handicap Surgical Risks".

The May 5 meeting of the society was addressed by Dr. J. W. Wilce, Columbus, on "Heart Disease".

At the April 21 meeting, Dr. C. R. Johnson, Cambridge, was the principal speaker.—News Clipping.

Licking County Medical Society held its regular meeting May 27 at the Moundbuilders' Inn, Newark. Following dinner, the society was addressed by Dr. C. A. Hyer, Columbus.—News Clipping.

Muskingum County Academy of Medicine met June 1 in the American Legion Headquarters, Zanesville. Dr. Lester Lasky read a paper on "Some Thoughts on Contraception" and Dr. M. A. Loebell reported on the recent annual meeting of the State Association at Dayton.—Bulletin.

Ninth District

Scioto—Regular June meeting of the Hempstead Academy of Medicine was held June 13 at the Nurses' Home, Portsmouth. The program consisted of a symposium on "Unusual Experiences in Obstetrics". A buffet supper was served following the program. The arrangements for the meeting were made by Dr. Tunis Nunemaker and Dr. W. A. Quinn.—Bulletin.

Tenth District

Crawford County Medical Society met June 6 at the Elks' Grill, Bucyrus. The principal speaker was Dr. Mark Millikin, Hamilton. Dr. Millikin spoke on "Recent Ideals of the Social Aspects of Medicine". A buffet supper was served following the program.—Bulletin.

Knox County Medical Society at its meeting

May 26 at the Alcove, Mt. Vernon, was addressed by Dr. E. Harlan Wilson, Columbus, who spoke on "The Maggot Treatment in Osteomyelitis".—News Clipping.

Madison County Medical Society met in regular session May 26 at the London Country Club. Following a chicken dinner the society was addressed by Dr. R. B. Drury and Dr. Paul Scofield, both of Columbus.—News Clipping.

Pickaway County Medical Society gave a dinner May 9 at the Pickaway Country Club honoring Dr. John B. May, New Holland, veteran member of the society on his 90th birthday.—News Clipping.

Deaths in Ohio

Frank F. Barger, M.D., Urbana; Miami Medical College, Cincinnati, 1903; aged 55; member of the Ohio State Medical Association and the American Medical Association; died May 7 from a throat infection. Dr. Barger, a practicing physician in Champaign County for more than 25 years, was a member of the American Legion and the Masonic Lodge. He leaves his widow, his father, two sons and two daughters.

William A. Belt, M.D., Kenton; Medical College of Ohio, Cincinnati, 1886; aged 69; former member of the Ohio State Medical Association and the American Medical Association; died May 14 following an extended illness. Dr. Belt, a native of Auglaize County, received his early education in the schools of Ottawa, Bellefontaine, Marion and Toledo. Following his graduation from Ohio Wesleyan University and medical college, Dr. Belt located in Kenton. He was a 33rd Degree Mason and was for many years one of the most prominent members of the lodge in Ohio. Dr. Belt had always been active in politics having served on the Ohio Centennial Board of Commissioners; as chairman of the Hardin County Republican executive committee and as a member of the State Republican Executive Committee. He was for eight years a member of the Kenton Board of Education and for 10 years a trustee of Ohio Northern University. Surviving him are his widow, two sons, Dr. LeRoy Belt, Marblehead and William A. Belt, Jr., of Toledo, and one daughter, Mrs. Rachel Ewbank, Madison, Wisconsin.

Isaac N. Bowman, M.D., Upper Sandusky; Starling Medical College, Columbus, 1882; aged 77; member of the Ohio State Medical Association and the American Medical Association; died June 2 following an extended illness. Dr. Bowman was born in Wyandot County. After attending Oberlin College, he studied medicine under the late Dr. Dennis W. Byron and later graduated with high honors at Starling Medical College. He also attended Hahnemann Medical College and the Chicago Eye, Ear, Nose and Throat Polyclinic. He leaves two sons, Dr. J. Craig Bowman, chairman of the Committee on Medical Economics of the Ohio State Medical Association, with whom he was associated in practice; Dr. Robert J. Bowman, Los Angeles; two daughters, Miss Bernice S. Bowman and Mrs. Marguerite Billhardt, both of Upper Sandusky, and three sisters.

John L. Brubaker, M.D., Deshler; Toledo Medical College, 1898; aged 61; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died May 10 of paralysis. Dr. Brubaker was a native of Defiance. He is survived by two brothers and two sisters.

Roy E. Brown, M.D., Washington C. H.; University of Chicago, College of Medicine, 1902; aged 56; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died June 1 of heart trouble. A native of Adams County, Dr. Brown attended the public schools at Washington C. H. Following his graduation from medical school, Dr. Brown was on the staff at Lakeside Hospital, Chicago, later moving to Devil's Lake, North Dakota, where he resided for several years before returning to Washington C. H. Dr. Brown was a past president of the Fayette County Medical Society; member of the county blind commission; physician at the County Home; former trustee at the Mt. Logan Sanitorium and resident surgeon for the B. & O. Railroad. At one time he was chairman of the city civil service commission and took an active part in political matters. Surviving are his widow, two step-children, his parents, and one sister.

Joseph E. Cook, M.D., Cleveland; University of Wooster Medical Department, Cleveland, 1881; aged 76; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died May 31. Dr. Cook was a former president of the Cleveland Academy of Medicine

and was a member of the consulting staff at Charity Hospital. His widow and two sisters survive.

Millard F. Deeren, M.D., Macksburg; Columbus Medical College, 1887; aged 72; died May 26 following a year's illness. He was a native of Pleasant City and had practiced at Macksburg for the past 45 years. Dr. Deeren leaves his widow, two brothers and one sister.

Isaac C. Edwards, M.D., Columbus; Starling Medical College, Columbus, 1882; aged 79; died May 17 of bronchial asthma. Dr. Edwards had practiced for two years at Fremont and Pickerington, moving in 1884 to Columbus. Surviving are his widow, one daughter and one sister.

Clark T. Elder, M.D., Cleveland; Ohio Medical University, Columbus, 1903; aged 55; former member of the Ohio State Medical Association and the American Medical Association; died June 2 following a stroke of paralysis. Dr. Elder practiced in Columbus for several years. He was assistant superintendent of the Cleveland State Hospital during the World War and was a Spanish-American War veteran. He is survived by a widow.

Harry B. Garrigues, M.D., Massillon; Cleveland University of Medicine and Surgery, 1883; aged 79; died May 10 following a brief illness. He had been a practitioner in Massillon for the past 33 years.

Jesse E. Hahn, M.D., Warsaw; Medical College of Ohio, Cincinnati, 1901; aged 61; member of the Ohio State Medical Association and the American Medical Association; died May 4 of heart trouble. Dr. Hahn had practiced in Tiverton and Brinkhaven before moving to Warsaw about 16 years ago. He was for three terms a township trustee; former member of the school board; member of the county board of health, and medical examiner for the county pension board. Dr. Hahn belonged to the Masonic Lodge and the Church of Christ. Besides his widow, he leaves two sons and two daughters, his mother, two brothers and two sisters.

Osear Haseneamp, M.D., Toledo; University of Tennessee, College of Medicine, 1887; aged 68; member of the Ohio State Medical Association and of the American Medical Association; died May 20. Dr. Hasencamp was a member of the staff at St. Vincent's Hospital and was a member of the Knights of Columbus and Elks' lodges. He had been a resident of Toledo for the past 40 years. He leaves two brothers.

William Hoover, M.D., Grove City; Columbus Medical College, 1880; aged 80; died April 28 following a long illness. Dr. Hoover had practiced at Grove City for 45 years, having returned to his native village after graduation from medical school. Dr. Hoover was a member of the board of education for 12 years. Surviving are his widow, one daughter, two brothers and two sisters.

John W. Hornby, M.D., Newark; Columbus Medical College, 1888; aged 74; died May 9 of paralysis. Dr. Hornby had practiced in Newark for the past 38 years. His widow and one son survive.

Howard C. Minor, M.D., Steubenville; Ohio Medical University, Columbus, 1897; aged 63; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died May 9 of heart disease at the home of his daughter, Mrs. Walter Drake, Cleveland. For 20 years Dr. Minor practiced in Steubenville and Toronto near there. He retired from practice several years ago because of his health. Besides his widow and daughter, Dr. Minor leaves one son, Dr. Howard Minor, Pittsburgh, two brothers and one sister.

Matthew T. Moorehead, M.D., West Lafayette; Medical College of Ohio, Cincinnati, 1889; aged 70; former member of the Ohio State Medical Association and the American Medical Association; died May 19 following three years' illness. Dr. Moorehead was a native of Muskingum County. He had practiced in Coshocton County since his graduation from medical school. He leaves his widow, two daughters, two sons, Dr. James R. Moorehead, Seville, and Dr. M. T. Moorehead, Jr., Kansas City, Mo.

Frank A. Morrison, M.D., Uhrichsville; Pulte Medical College, Cincinnati, 1890; aged 73; former member of the Ohio State Medical Association; died May 5 of hernia. Dr. Morrison had practiced in Uhrichsville for the past 32 years. Surviving are his widow, three daughters and one brother.

Gamaliel C. Myers, M.D., Dayton; Cincinnati College of Medicine and Surgery, 1880; aged 86; died May 24 of paralysis. After graduating from medical college, Dr. Myers entered Queen's College, Dublin, Ireland. After his graduation there, he located in Dayton where he had practiced for the past 50 years. Dr. Myers was a 33rd Degree Mason, and a member of the Pythian Lodge. He also was active in politics, having at one time served as county coroner. During the Civil War, Dr. Myers saw three years of active service and was imprisoned in Libby Prison for a short time. His widow survives.

George S. Patterson, M.D., Pattersonville; School of Medicine, Western Reserve University, 1893; aged 64; died May 10 following a four-months illness. He was a native of Pattersonville and had practiced for the past 40 years in Pattersonville and Minerva. He leaves two brothers and a sister.

William H. Rabberman, M.D., Forest; Starling

Medical College, Columbus, 1906; aged 58; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died June 6. Dr. Rabberman had practiced at Forest since graduation from medical school. His academic education was received at Ohio Wesleyan University. During the World War, Dr. Rabberman served as a captain in the medical corps. He was a trustee of McKitrick Hospital, Kenton, and was active in civic, church and school affairs of his home city and county. His widow, three daughters and two sons survive.

Frank S. Thomson, M.D., Dayton; University of Louisville School of Medicine, 1888; aged 65; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died May 22. Dr. Thomson had been a resident of Dayton since 1898. He was a surgeon for the Baltimore and Ohio Railroad and at one time was a member of the city board of health. During the World War, Dr. Thomson was a member of the Dayton draft board. Surviving are his widow, one daughter, one son, one sister and one brother.

Jasper E. Wagner, M.D., Paris; Starling Medical College, Columbus, 1896; aged 65; died May 30. Dr. Wagner had practiced at Paris for the past 36 years. He was a member of the staff of the Alliance City Hospital. He leaves his widow and one sister.

Arthur W. Wheeler, M.D., Toledo; Toledo Medical College, 1902; aged 57; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died May 9 of appendicitis. Dr. Wheeler was a native of Clinton County, Iowa. Surviving are his widow, one son, one daughter, his mother, three sisters and two brothers.

Starling S. Wilcox, M.D., Columbus; Starling Medical College, Columbus, 1888; aged 68; former member of the Ohio State Medical Association and of the American Medical Association; died June 1 following three months' illness. Dr. Wilcox, great grandson of Lucas Sullivant, founder of Columbus, received his early education in the Columbus public schools. After attending Phillips Exeter Academy, he entered medical school. During the Spanish-American War, Dr. Wilcox served as a captain in the Medical corps and during the World War served as major in charge of the base hospital at Camp Selby, Mississippi. After the World War, he served until 1928 as state supervisor of the United States Veterans' Bureau. Dr. Wilcox was a Fellow of the American College of Surgeons, a member of Alpha Kappa Kappa medical fraternity, and the Starling Loving Medical Society. He leaves two sons, one sister and one brother.

William Wilson, M.D., Akron; Pulte Medical College, Cleveland, 1899; aged 71; former member of the Ohio State Medical Association and the American Medical Association; died June 2 of coronary thrombus. Dr. Wilson was a native of Leeds, England.

KNOWN IN OHIO

Clarence E. Applegate, M.D., Long Beach, California; Rush Medical College, Chicago, 1927; aged 34; died following an automobile accident. Dr. Applegate was a native of Richland County, Ohio, and had attended Wooster College. He was located in Cleveland and Buffalo before moving to California. His mother, Mrs. Mary Bowman Applegate, resides at Perrysville.

Edward M. Boggess, M.D., Elwood, Indiana; Medical College of Ohio, Cincinnati, 1887; aged 69; died May 31. Dr. Boggess 20 years ago practiced in Fayette and Brown Counties. He leaves his widow and two sons.

John Alden Lichty, MD., Clifton Springs, N. Y., University of Pennsylvania School of Medicine, 1893; aged 66; died May 2 at Clifton Springs where he was superintendent of the tuberculosis sanitorium. Dr. Lichty, a brother of the late Dr. Milton J. Lichty, Cleveland, former member of the Council of the Ohio State Medical Association, was graduated from Mount Union College in 1890 and was a trustee of that college at the time of his death. He was at one time a member of the medical faculty at the University of Pittsburgh and was a trustee of Rochester Theological Seminary. Surviving are his widow, two daughters and two sons. Dr. Lichty was a member of many medical societies, including the American Medical Association, American College of Physicians, American Gastro-Enterological Association, American Climatological and Clinical Association and the American Psychiatric Association.

Eber D. McKinley, M.D., Alamogordo, New Mexico; Central College of Physicians and Surgeons, Indianapolis, 1904; aged 56; died May 18 of heart trouble. Dr. McKinley was a native of Athens County and spent his early life there. After graduating from medical school he located in Indiana and later moved to New Mexico. Surviving are his widow, two sons, one daughter, and two brothers, D. J. and P. H. McKinley of Athens County.

Harvey C. Maurer, M.D., Beloit, Wisconsin; State University of Iowa, College of Medicine, Iowa City, 1905; aged 50; died April 7, of carbon monoxide poisoning. Dr. Maurer practiced for a while at New Bremen following his graduation from medical school. Surviving are his widow, three sisters and one brother.

A Twenty Year Study of Births and Deaths Reveals Interesting Data in Ohio

Interesting data relative to the health and mortality of Ohioans during the past 20 years, the changing birth rate during that period, and the decrease in the foreign population of the state during the past 10 years, are found in a voluminous summary of death, birth and population statistics recently compiled by I. C. Plummer, chief of the Bureau of Vital Statistics, State Department of Health.

According to the tabulation of deaths in Ohio for the years 1910-1930 inclusive, the death rate in the state for 1930 (11.4 per 1000 population) was lower than for any other year in the period with the exception of the years 1921, 1922, 1924 and 1927.

The complete summary of deaths in the state from 1910 to 1930 inclusive is as follows:

Years	*Deaths*	*Rate*	*Males*	*Females*	*Urban*	*Rural*
1910	65532	13.7	35265	30267	36327	29205
1911	63385	13.1	33959	29426	35642	27743
1912	65411	13.3	35406	30005	35737	27871
1913	68399	13.8	37293	31106	40324	28075
1914	65077	12.9	35262	29815	37878	27199
1915	66070	12.9	35508	30562	38575	27494
1916	74230	14.4	40905	33325	44366	29864
1917	76893	14.8	43151	33742	46975	29918
1918	93965	17.8	52197	41768	58348	35617
1919	72592	12.7	38397	34195	45004	27588
1920	73846	12.7	38702	35144	46745	27101
1921	67100	11.3	34932	32168	41176	25924
1922	68019	11.3	35705	32314	42145	25874
1923	75066	12.3	39529	35537	46902	28164
1924	69912	11.2	37257	32655	44431	25481
1925	73549	11.6	38672	34877	46868	26681
1926	78675	12.2	41414	37261	50413	28262
1927	73466	11.3	39060	34406	47433	26033
1928	80146	12.1	42743	37403	51828	28318
1929	81306	12.1	43648	37648	52539	28767
1930	76216	11.4	41260	34956	50309	25907

Detailed information concerning the death rates in 1930 in the various counties and cities, the number of deaths in the various age periods and according to race, and the most common causes of death, also is contained in the report.

Gallia County with a death rate of 19.4 had the highest rate among the 88 counties of Ohio in 1930 and Summit County with a rate of 7.7 the lowest. It was pointed out, however, that Gallia County is the seat of a state institution (the Ohio Hospital for Epileptics) and that among the counties not having a state institution, Morgan County with a death rate of 17.9 had the highest rate.

The city without a state institution having the highest death rate was Kenton, with a rate of 20.4. The lowest death rate for any city was recorded in Grandview, with a rate of 3.5. Gallipolis with a state institution located there had a death rate of 39.1, the highest of any city in the state.

There were 7,194 deaths of children under one year of age in 1930, compared with 8,0032 deaths in 1929. More deaths occurred in the age period from 70 to 74 years (7,676) than in any other age period. In this group six causes were responsible for 77 per cent of the deaths, namely: Heart disease, 2,262; cerebral hemorrhage, 1,138; cancer, 1,014; nephritis, 792; pneumonia, 377, and accidental, 329.

During 1930, there were 175 deaths of persons over 95 years of age, 68 being males and 107 females. Six deaths of persons over 100 years of age were reported. More deaths occurred during the month of April (7,325) and fewer in the month of June (5,791), than any other month of the year.

The death rate in 1930 for the white population of the state was 11.1 or 70,474; the negro race, 18.3 or 5,719, and for all other races, 30.4 or 194.

Five causes of death were responsible for 54.2 per cent of all deaths reported in 1930 or 41,317, namely: Heart disease, 15,200; cancer, 7,085; cerebral hemorrhage, 7,009; accidental, 6,707, and nephritis, 5,316. It is pointed out that during the year 1920, these five causes of death were responsible for only 39.7 per cent of all deaths reported.

Analysis of births in Ohio during the period 1909-1930, inclusive, reveals that the birth rate in 1930 (17.6) was the lowest for any year in that period with the exception of the years 1912 and 1929.

The comparative summary of births in the state from 1909 to 1930, inclusive, is as follows:

Years	*Births*	*Rate*	*Males*	*Females*	*White*	*Negro*	*Other*
1909	100160	21.4	51584	48576	97883	2105	7
1910	100969	21.1	51896	49073	98988	1954	27
1911	97017	19.8	49954	47063	95094	1897	26
1912	84164	16.9	43483	40681	82406	1745	13
1913	89979	17.7	46197	43782	88226	1745	8
1914	101801	19.6	52033	49768	99809	1974	18
1915	105901	19.9	54381	51520	103821	2066	14
1916	112939	20.9	58244	54695	110778	2137	24
1917	121804	22.1	62795	59009	119071	2723	10
1918	124629	22.2	64243	60386	121850	2764	15
1919	112719	19.7	57907	54812	109383	3310	26
1920	124303	21.4	63765	60538	120403	3883	17
1921	130860	22.1	67638	63222	126271	4568	21
1922	122939	20.4	62835	60104	118977	3933	29
1923	128785	21.1	66241	62544	123444	5301	40
1924	132048	21.2	67892	64156	125510	6492	46
1925	127358	20.2	65732	61635	121065	6238	55
1926	124258	19.3	63803	60455	117865	6353	38
1927	123425	18.9	62997	60428	117181	6200	44
1928	120488	18.2	61835	58653	114126	6321	41
1929	116433	17.3	60082	56351	110317	6081	35
1930	117611	17.6	60766	56845	111416	6152	43

Additional data is contained in the summary relative to the 1930 birth rates of urban and rural districts, the number of births to women in the various age periods, the number of births attended by physicians, etc.

Of the total number of births in Ohio in 1930 (117,611), 79,836 occurred in urban districts and 37,775 in rural districts. The birth rates for

these two sections were: Urban, 18.6; rural, 15.9.

During 1930 there were 1219 sets of twins and 13 sets of triplets born; 111,416 children born to white parents with a rate of 17.5; 6152 born to negro parents, with a rate of 19.7; 35 Chinese, 4 Japanese and 4 Indian children born.

Scioto County with 1990 births and a rate of 24.4 led all the counties of the state in 1930 and Carroll County with 193 births and a rate of 12.0 had the lowest birth rate. Among the cities Wadsworth with 187 births and a rate of 31.5 had the highest birth rate and Oakwood with 4 births and a rate of .6 the lowest.

One hundred and thirteen children were born to mothers 15 years of age or younger; 179 to mothers 46 years of age or more; 7,558 to mothers 22 years of age; 7,520 to mothers 23 years of age; 75,176 to mothers 24 years of age. The summary shows that 38,315 mothers gave birth to their first child; 7,658 to the second; 16,974 to the third; 11,314 to the fourth; 7,658 to the fifth; 1,177 to the tenth; 696 to the eleventh; 437 to the twelfth; 229 to the thirteenth; 131 to the fourteenth; 78 to the fifteenth; 28 to the sixteenth; 14 to the seventeenth; 5 to the eighteenth, and that 3 gave birth to their nineteenth child.

A total of 115,623 birth records were signed by physicians, 1525 by midwives and 463 by parents. Children born in hospitals totaled 29,344; those born in the home, 86,279, and those in institutions, 3.

Population statistics compiled by the bureau revealed that on April 1, 1930, the foreign population of Ohio totaled 644,151, compared to a foreign population of 680,452 on January 1, 1920.

The report pointed out that the estimated population of the state on July 1, 1931, was 6,668,338 of which 2,376,598 was rural and 4,291,740 was urban.

Interpreting Statistics on Heart Disease Deaths

Much is heard nowadays concerning the rapid and alarming increase in the number of fatalities from heart disease, ranked at present as the principal cause of death. Statistics gathered from various sources are cited. Special organizations, societies and groups have been organized to stem the ever-increasing tide of mortality from this cause.

Of late, however, due to rational and unemotional analysis of the data assembled on this subject, not a few authorities who are in a position to discuss intelligently the various causes for the actual increase in death from heart disease, have arrived at the conclusion that this seems *in part* to be a "health fallacy", rather than a "health fact", as widely advertised.

A clear-cut explanation of how the indiscriminate use of statistics, minus analysis and appraisal, has painted a misleading picture of the actual situation regarding heart disease is found in an article, "Health Facts—What to Tell", by Dr. Donald B. Armstrong, published in a recent issue of *The American Journal of Public Health.*

Dr. Armstrong classifies much of the propaganda concerning heart disease as a health fallacy, in part at least. He admits that the steady increase in the number of deaths from heart disease of all forms and at all ages is a reality, but points out that three principal elements must be considered to present a true picture of the situation.

"First", he declares in analyzing the heart disease picture, "it includes children and young adults under 45, where deaths from heart disease are a tragedy and a disaster. Perhaps in most cases, the etiological factors here are the acute infections resulting in heart tissue injury. Prevention largely involves the control of these infections. The incidence of these infections, such as diphtheria, scarlet, typhoid and acute rheumatic fevers, is markedly decreasing, a factor that may be related to another significant observation, the recent very definite decline in heart fatalities at these ages. This, the most important age group sector in the heart disease range, presents a trend that is not only not alarming, but decidedly reassuring and encouraging.

'Second, the heart disease picture also includes the age group from 45 to 65 to 70, where deaths from heart disease are certainly unfortunate. It is thought that they result partly from acute infective injuries, but more from syphilis. Prevention means mainly the control of syphilitic infection, and particularly the prevention of the advanced stages of syphilis by detection and adequate treatment. It is possible materially to affect heart disease mortality in this middle age group by these control measures as well as by personal hygiene, the periodic health examination, or the practice of physiological thrift. That seems probable, so that here too, as well as in the younger age group, the picture is not discouraging.

"Third, the heart disease picture includes, of course, the senescent, old-age, degenerative type occurring usually beyond 65 to 70. Deaths from heart disease in this age group are increasing, and are inevitably bound to increase as the population ages, and as larger groups survive to invade this age period. Heart failure is an inevitable incident in this age group. On the other hand, here it certainly is not a tragedy as it is among young adults, nor the unfortunate factor it is in the middle age population element. In fact, it is almost a natural process, and in a great many cases, a benign, beneficent process, furnishing an easy and painless as well as an unprotracted termination of life.

"From the point of view of health facts, it is important to distinguish between these three elements. To present the general combined death rate from heart disease as an increasing and inevitable menace is obviously misleading and unduly discouraging. This increasing rate is real, but is neither altogether deplorable nor alarming. Furthermore, it is certainly in part the inevitable and desirable sequitur of disease prevention and life prolongation in the earlier age groups. This is a case where analysis and appraisal are essential to the presentation of a true picture for public view, and indeed for constructive, hopeful action."

NEWS NOTES of OHIO

Urbana—Dr. Lewis Inskeep has opened offices here. He is a former intern at Springfield City Hospital.

Mt. Vernon—Members of the Knox County Medical Society will close their offices at noon on Thursday during July, August and September.

Cincinnati—Dr. Paul D. Grove, Cincinnati, was inaugurated as president of the Ohio State Homeopathic Medical Society at the annual meeting of the society here in May. Other officers are: Dr. W. E. Allyn, Cleveland, president-elect; Dr. L. L. Chandler, Cleveland, secretary; Dr. Charles E. Geiser, Cincinnati, vice president; Dr. T. T. Church, Salem, treasurer.

Columbus—Announcement has been made of the marriage of Miss Elsie Schneider and Dr. W. E. Elder, both of Columbus. Dr. Elder is assistant chief medical examiner for the State Industrial Commission.

Barnesville—Dr. Paul Modi, formerly an intern at Grant Hospital, Columbus, has leased quarters here for offices.

Fostoria—Offices have been opened here by Dr. William G. Hartnett, formerly of Toledo.

Wilmington—The local Commercial Club was addressed recently by Dr. Robert Conard on "Curiosities in the History of Medicine".

Circleville—Announcement has been made of the marriage of Mrs. Harriett Tullis and Dr. A. W. Holman, both of this city.

Lorain—Dr. John W. Adrain has resumed his practice after completion of a post-graduate course at the University of Indiana Medical School.

Swanton—Dr. L. C. CosGrove and Mrs. CosGrove have returned from New Orleans where the former has been taking post-graduate work at Tulane Medical School.

Sidney—Dr. C. S. Yinger has opened offices here for the general practice of medicine. He is a graduate of Jefferson Medical College and a former intern at the Springfield City Hospital.

Sandusky—At a meeting of the Men's Literary Club, Dr. Julius Kramer read a paper on "Medical Economics".

Cincinnati—Dr. Bronson Crothers, Boston, lectured at the second annual series of Benjamin Knox Rachford lectures, conducted at the University of Cincinnati under the auspices of the Department of Pediatrics, April 22 and 23.

Cincinnati—"Civilization's Debt to Medicine" was the subject of an address made by Dr. A. C. Bachmeyer, dean of the College of Medicine, University of Cincinnati, before the Masonic Forum.

Wellsville—A dinner party honoring Dr. M. C. Tarr, who has completed 50 years in the practice of medicine, was given May 12 at the First Presbyterian Church by the local Kiwanis Club. Dr. J. S. McCulloch was program chairman and toastmaster. The principal address of the evening was made by Dr. J. J. Buchannan, Pittsburgh surgeon and a life-long friend of Dr. Tarr. A tribute to Dr. Tarr also was paid by Dr. W. A. Hobbs, East Liverpool, in presenting Dr. Tarr a watch from the club.

Plymouth—Dr. C. S. Hannum, formerly connected with Lakeside Hospital, Cleveland, has opened offices here.

Columbus—Announcement has been made of the engagement of Miss Charlotte White, daughter of Governor George White, and Dr. Frank E. Hamilton, house physician at Grant Hospital, Columbus.

Cambridge—Dr. Gordon Lawyer has resumed active practice following five-months post graduate work at the New York Polyclinic Hospital, New York City.

Cincinnati—Dr. Charles E. Howard was elected vice president of the American Proctologic Society at the annual meeting of the society at Memphis, Tenn.

Sandusky—Dr. Paul N. Squire addressed the St. Paul's Brotherhood on the subject, "State Medicine".

Marysville—The local Kiwanis Club was addressed recently by Dr. E. F. McCampbell, Columbus. Members of the Union County Medical Society were guests of the club.

Toledo—Dr. B. B. Brim, who has not been in active practice for several years, has announced his intention to resume practice in the near future.

Portsmouth—Dr. George D. Blume has been employed as city physician.

Cincinnati—Dr. Johnson McGuire has been

made an assistant professor of medicine at the College of Medicine, University of Cincinnati.

Cleveland—Dr. Robert H. Bishop has been elected a graduate trustee of Western Reserve University.

Cleveland—Dr. Elliott C. Cutler, formerly professor of surgery at the School of Medicine, Western Reserve University, has moved to Cambridge, Mass., where he will succeed Dr. Harvey Cushing as professor of surgery at Harvard Medical School.

Marion—Dr. W. L. Layport was installed as president of the Ohio Eclectic Medical Association at its annual meeting here in May. Dr. H. E. Dwire, Bucyrus, was elected president-elect. Other officers elected were: Dr. M. E. Bowles, Cincinnati, vice president; Dr. G. E. Jones, Lima, recording secretary; Dr. George Hite, Toledo, corresponding secretary and Dr. F. L. Thomas, Marion, treasurer. The 1933 meeting will be held at Cedar Point.

Cambridge—Dr. Paul O. Huth has purchased the interest of Dr. H. L. Wells in the Wells Hospital of which the former's father, Dr. F. C. Huth, is part owner.

Cincinnati—A farewell dinner honoring Dr. George J. Heuer was given recently at the Cincinnati Country Club at which more than 200 local and out-of-town physicians were present. Dr. Heuer formerly professor of surgery at the College of Medicine, University of Cincinnati, will soon take up his new duties as chief of the surgical staff of the New Cornell Medical Center, New York City. Dr. A. Graeme Mitchell was toastmaster. Those who spoke were Dr. George W. Crile, Cleveland, and Dr. Albert H. Freiberg, Cincinnati.

Columbus—Dr. Eli G. Alcorn sustained a fractured hip in a fall at his home here.

Columbus—Announcement has been made of the marriage of Miss Adria L. Stockdale, principal of nurses at the Columbus State Hospital, and Dr. George Y. Swickard, Oberlin.

Dayton—Dr. Walter M. Simpson, head of the pathologic laboratories, Miami Valley Hospital, was installed as president of the American Society of Clinical Pathologists at its recent annual meeting at New Orleans.

Chillicothe—Dr. Samuel M. Sproat spoke on "Surgical Progress" at a meeting of the Sunset Club. The paper was discussed by Dr. L. E. Hoyt.

Defiance—Announcement has been made that Dr. John U. Fauster, Jr., has joined his father, Dr. J. U. Fauster, in the practice of medicine, following several years' at the Mayo Clinic, Rochester, Minn.

Cleveland—Dr. Torald Sollmann, dean of the School of Medicine, Western Reserve University; Dr. Carl J. Wiggers, professor of physiology, and W. F. von Oettingen, assistant professor of pharmacology, attended a meeting of the Federation of American Societies for Experimental Biology, at Philadelphia.

Cincinnati—The Cincinnati Academy of Medicine has leased quarters on the 17th floor of the Union Central Building for academy meetings, club rooms and committee gatherings.

Xenia—Dr. H. C. Schick was host to the Cabot Club, composed of Greene County physicians.

Cincinnati—Dr. Richard S. Austin was a recent speaker before the Torch Club.

Coshocton—The local Kiwanis Club was addressed recently by Dr. W. H. Keenan.

Ashland—Dr. Allen F. Mowery recently celebrated the 50th anniversary of his entrance into the active practice of medicine.

Cincinnati—Dr. A. Graeme Mitchell, professor of pediatrics, College of Medicine, University of Cincinnati, has been elected to the National Board of Medical Examiners, as a representative of the Association of American Medical Colleges.

Cleveland—Dr. R. E. Barney and Dr. E. W. Netherton read papers at the recent meeting of the American Dermatological Association at Havana. Dr. John A. Gammel and Dr. J. E. Rauschkolb were elected to membership.

Cleveland—Dr. Charlotte Kusta has completed two-months post-graduate work at the New York Polyclinic Hospital.

Cleveland—Dr. H. T. Karsner recently addressed a meeting of 100 high school students at Kenyon College, a conference to aid young men about to enter college in the choice of a career.

Cleveland—Dr. M. A. Blankenhorn recently participated in a clinic at the University Hospital, Ann Arbor, Michigan, held in connection with the 50th anniversary convention of Nu Sigma Nu.

Oberlin—Dr. R. W. Bradshaw has returned from Cambridge, Mass., where he attended a series of post-graduate lectures at Harvard Medical School.

Carrollton—Dr. Carl A. Lincke, formerly of Alliance and recently an intern at White Cross Hospital, Columbus, has opened offices here.

Mansfield—Dr. G. W. Jacoby recently took post-graduate work at the Mayo Clinic.

Columbus—Dr. J. H. J. Upham, dean of the College of Medicine, Ohio State University, addressed the Starling-Ohio Women's Club on

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Wilmington—Dr. W. L. Regan has been commissioned a first lieutenant in the Medical Officers Reserve Corps.

Uniontown—A community celebration was held here June 2 in commemoration of the 79th birthday of Dr. Milton M. Bauer, a practitioner here for the past 52 years. The program at the St. John's Lutheran Church consisted of addresses by Dr. Carl F. Steinke, Akron; Dr. H. M. Schuffell, Canton; and prominent citizens of Uniontown; and music including a complete program by the Doctors' Symphony Orchestra of Akron, directed by Dr. A. S. McCormick.

Cleveland—The following members of the senior medical class at Western Reserve University have been elected to membership in Alpha Omega Alpha, honorary medical society: Curtiss Ferbert Garvin, Joe I. Goodman, William R. Hallaran, Elizabeth S. Hutchison, Reuben R. Maier, Harold Rand and Howard Stephens, of Cleveland, and Norma Reider, Canton.

Cincinnati—Dr. W. D. Haines has been elected president of The Academy Journal Publishing Company, publishers of *The Journal of Medicine*, succeeding the late Dr. C. L. Bonifield. Dr. Mont R. Reid, professor of surgery, College of Medicine, University of Cincinnati, has been named to the board of directors, filling the vacancy created by the death of Dr. Bonifield.

Cincinnati—Dr. L. B. Arey, professor of anatomy, Northwestern University, was the principal speaker at the banquet which preceded the first annual initiation of the Cincinnati Chapter of Pi Kappa Epsilon, honorary medical fraternity.

Toledo—Dr. J. T. Murphy was elected secretary of the Radiological Section of the American Medical Association at the recent A.M.A. meeting at New Orleans.

Toledo—Dr. J. A. Muenzer presented a paper on "The Physical Health of the Institutional Child" before the recent National Social Workers' Conference at Philadelphia.

Cincinnati—The following appointments and promotions at the College of Medicine, University of Cincinnati, have been approved by the Board of Directors, effective September 1, 1932:

Dr. Henry F. Hollenberg, Proctor fellow and instructor; Dr. E. V. Ferguson, assistant and anonlymous fellow; Dr. John V. Goode, resident surgeon and surgery department fellow; Dr. William M. Millar, instructor; Drs. Robert J. Tapke, Albert E. Moore, Henry Les, Josiah Smith, Daniel E. Earley, Paul Merrell, E. A. Kindel and Harry L. Fry, assistants in the surgical service; Drs. Ralph Fuller, Sidney Mendelsohn, Sander Cohen and Irving B. Gold, assistants in the department of pathology; Dr. Harry L. Claassen, promoted from assistant to instructor in dermatology and syphilology; Dr. Esther Bogen Tietz, temporary research assistant in physiology.

Wilmington—Dr. Kelley Hale and his two sons, Myron and Nathan, have returned from a 4,000 mile automobile trip through the South, during which Dr. Hale attended the New Orleans session of the A.M.A.

Portsmouth—Dr. Frank Siedenburg, for the past eight years assistant to Dr. H. A. Schirrman, has moved to New Falls, North Dakota, his former home.

Cleveland—Norman Reider, Canton, has been awarded the Steuer Memorial Prize, awarded annually to the student at Western Reserve University doing the most meritorious piece of research in anatomy.

Cleveland—The senior prize in obstetrics at the School of Medicine, Western Reserve University, has been awarded to Elizabeth S. Hutchison, the first time in the history of the school this award has gone to a woman.

Cincinnati—The following Cincinnati physicians were speakers at recent scientific and medical gatherings: Dr. Samuel Iglauer, American Laryngological, Rhinological and Otological Society; Dr. Mont R. Reid, American Surgical Association; Dr. Harris H. Vail, American Otological Society; Dr. Roger Morris, Association of American Physicians.

Columbus—The following Columbus physicians have been appointed to the public health committee of the Columbus Chamber of Commerce: Drs. C. H. Benson, chairman; Hugh G. Beatty, H. O. Bratton, John Edwin Brown, Ivor G. Clark, J. J. Coons, Robert B. Drury, John Dudley Dunham, E. J. Emerick, A. D. Frost, Fred E. Hall, Charles S. Hamilton, Edwin Hamilton, I. B. Harris, Arthur M. Hauer, Arthur G. Helmick, W. D. Ingl's, Bruce E. Lindsey, L. M. Lisle, E. F. McCampbell, Charles W. McGavran, Russel G. Means, Joseph A. Murphy, John Rauschkolb, Andrew Timberman, James H. Warren, C. H. Wyker, John H. Mitchell, S. J. Goodman and W. H. Pritchard.

Melmore—Members of the Odd Fellows Lodge gave a surprise party in honor of Dr. R. G. Steele, who celebrated his 75th birthday recently. He has been a member of the lodge for 43 years.

New Holland—Dr. and Mrs. J. B. May recently celebrated their sixtieth wedding anniversary. Dr. May, president emeritus of the Pickaway County Medical Society, was 90 years old on May 2. Mrs. May is 82 years of age. Dr. May recently retired after 57 years of active practice.

Bethel—Dr. Eberly Thompson, who will celebrate his 96th birthday in July, recently completed his 72nd year in the practice of medicine.

Wooster—A group of 11 Wooster physicians called recently at the home of Dr. J. H. Todd to congratulate him on his 95th birthday anniversary.

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Medical-Military Training For Reserve Officers in Cleveland in October

Through the courtesy of the authorities of Western Reserve University and the hospitals of Cleveland, arrangements have been made whereby there will be given a period of 14 days inactive duty training for Medical Department Reserve Officers, without expense to the government, from October 9 to 22, according to an announcement by Colonel O. G. Brown, Corps Area Surgeon, Fifth Corps Area, Fort Hayes, Columbus.

Detailed announcement of the program of instruction will be issued at a later date. Applications for the Cleveland training course are being received by Brigadier General George W. Crile, med-res., commander of the Cleveland Inactive Duty Training Unit, 93rd and Euclid Avenue, Cleveland. Applications will be forwarded to the Corps Area Surgeon, Fifth Corps Area for final approval. Those from officers residing outside of the Fifth Corps Area, should be forwarded through their respective corps area commanders.

Emphasizing the importance of the forthcoming Cleveland training period, Colonel Brown in his announcement stated:

"For the past three years such courses have been given with marked and growing success at the Mayo Foundation, and a similar course was established last year at Washington University, St. Louis, Missouri. The course offered at Cleveland is the first course to be given outside of the Seventh Corps Area, and is the only course that will be offered in the Fifth Corps Area during the current fiscal year.

"These courses, to Medical Department Reserve Officers, present a two-fold advantage: (a) medico-military instruction; (b) refresher course in professional subjects. The courses are so arranged that a reserve officer can devote his morning hours to a well arranged schedule at the Cleveland hospitals—Lakeside (University Hospital), City Hosiptal, St. Luke's Hospital, Charity Hospital, Marine Hospital and the Cleveland Clinic, collaborating, together with instruction at the School of Medicine and the Pathological Institute. The afternoon and evening hours will be assigned to medico-military subjects, the Cleveland Medical Library Association and the School of Medicine having offered their rooms.

"The custom of taking annual study courses has become so general among medical men that statements about its advantages are unnecessary. Patriotic motives in the interest of National Defense and the desire of reserve officers for advancement in the military service have created a demand for this opportunity where both ends can be served. Aside from the excellent opportunities for medical post-graduate work, this course offers a credit of 100 hours toward reappointment, and credit of 14 days active duty training toward promotion, to any officer taking the entire course and receiving an efficiency report of at least satisfactory; proportionate allowances of credit will be given for partial attendance."

HOSPITAL NOTES

—Harry Neal Smith, attorney and former U.S. commissioner, addressed the staff at St. Mary's Hospital, Cincinnati, on "Doctor and Law".

—Reorganization of the staff at the People's Hospital, Akron, has been announced. A clinical staff of 76 physicians has been appointed. Divisional heads are: Neurology, Dr. R. E. Pinkerton; proctology, Dr. K. H. Harrington; dermatology, Drs. H. E. Blass and J. S. Millard; electro-cardiology, Dr. E. R. Stumpf; radiology, Dr. J. H. Selby; pathology, Dr. F. C. Potter; urology, Dr. Samuel Miller, with Dr. H. W. Reed, as assistant; pediatrics, Dr. William Lyons; anesthesia, Drs. O. P. Allen, J. G. Griffin, A. S. McCormish, S. Michael and F. B. Murphy. The board of consultants is composed of Drs. R. H. McKay, J. G. Blower, B. H. Hildreth, J. D. Smith, C. E. Held, S. E. McMasters, E. B. Dyson, J. C. McClelland and L. L. Bottsford.

—The final of a series of clinical lectures was held at the Detwiler Memorial Hospital, Wauseon, May 26 wtih 80 physicians from Northwestern Ohio in attendance. The morning program consisted of a lecture by Dr. F. A. Coller, professor of surgery, University of Michigan, on "Post-Operative Pulmonary Complications". Following a luncheon, Dr. W. G. Maddock, department of surgery, University of Michigan, lectured on "Peripheral Circulatory Changes" and "Treatment of Varicose Veins". The concluding lecture was made by Dr. Charles Brown, associate professor of medicine, University of Michigan, on "Diagnosis and Care of Peptic Ulcers". The program was arranged under the direction of Dr. R. W. Reynolds, secretary of the hospital staff.

—The Holzer Hospital, Gallipolis, recently celebrated its 22nd birthday anniversary. A special edition of the *Gallipolis Tribune*, consisting of 28

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pages, was dedicated to the hospital and to its founder, Dr. C. E. Holzer.

—Dr. D. M. Blizzard was named president of the medical staff of the Middletown Hospital. Other officers are: Dr. W. H. Williams, vice president, and Dr. E. T. Storer, secretary.

—Dr. R. S. Fidler, for the past two years chief pathologist at the Springfield City Hospital, has resigned to become head of the department of pathology, White Cross Hospital, Columbus.

—The new $2,000,000 Good Samaritan Hospital, Dayton, was dedicated recently and has been thrown open to the public.

—Dr. J. A. Stout has been elected chief of staff at St. Anthony's Hospital, Columbus.

—E. E. Opdyke, formerly of Newark, has been named superintendent of the Thomas Hospital, Mansfield.

—Dr. T. H. Copeland has been named chief of staff at the Bedford Municipal Hospital.

—A department of bronchoscopy has been added to the Youngstown Hospital. The department will be operated by Dr. E. C. Goldcamp, director, Dr. O. J. Walker, Dr. H. J. Beard, Dr. F. J. Bierkamp and Dr. F. F. Piercy.

—The medical library and surgical equipment of the late Dr. William A. Pitsele has been presented to St. Joseph's Hospital, Lorain, by Nelson Pitsele, son of the late physician. The library consists of 300 volumes of modern medical and surgical works.

—The medical staff of the Toledo Women's and Children's Hospital has re-elected the following officers: Dr. W. W. Brand, president; Dr. Will Gardiner, vice president; Dr. H. B. Meader, secretary.

—Specifications are being drawn for a $30,000 psychopathic institute at the Jewish Hospital, Cincinnati.

—At the annual banquet of the staff of the Schirrman Hospital, Portsmouth, the following officers were elected: Dr. H. A. Schirrman, president and chief of staff; Dr. Walter H. Sisson, vice president and Dr. Frank Siedenburg, secretary. The officers and Dr. Harwood Taylor and Dr. William Schaefer compose the executive board. Other members of the staff are: Drs. James Murfin, Ross M. Gault, A. O. Brooke, R. H. Ruhmkorff, L. B. Hatch, Elizabeth Taylor, O. L. Grey, I. P. Seiler, H. K. Moore, H. A. Green, W. A. Ray and G. W. Fishbaugh.

—Dr. J. A. Diekmann has been re-elected president and superintendent of the Cincinnati Bethesda Hospital.

—Mrs. Alma G. White has resigned as superintendent of the New London Hospital.

—An annex with 300 beds to the Cleveland Marine Hospital has been authorized by the Federal hospital building commission.

PUBLIC HEALTH NOTES

—Cincinnati took first place among cities between 250,000 and 500,000 population in the 1931 nation-wide Health Conservation Contest, sponsored by the U. S. Chamber of Commerce.

—A well-attended meeting of the Southwest District, Ohio Federation of Public Health Officials, was held at the Troy Country Club, May 25. Among those who addressed the gathering were Dr. W. D. Bishop, health commissioner of Greenville and Darke County, and Mrs. E. P. August, secretary of the Ohio State Nurses' Association.

A meeting of the Central District was held on April 21 at Portsmouth, and one of the Northwest District at Lima on April 14.

The Central District meeting was presided over by Dr. O. D. Tatje, health commissioner of Portsmouth. Talks were made by Major R. G. Bryan, Portsmouth; Dr. H. G. Southard, state director of health, Columbus, and Dr. Leon Solomon, Louisville, Ky.

Dr. Roy C. Hunter, health commissioner of Auglaize County, presided at the Central District conference at which public health questions of a general nature were discussed.

—Dr. G. D. Sheets, Williamsport, has been appointed a member of the Pickaway County Board of Health. He is a past president of the Pickaway County Medical Society.

Dr. R. W. DeCrow, formerly health commissioner of Scioto County, received a grade of 94.15, the highest given, in recent examinations for medical inspector in the State Department of Health.

At a recent meeting of the Public Health Council, Regulations 139 and 140 of the Ohio Sanitary Code were amended to exclude provisions heretofore applicable to licensed chiropodists and make

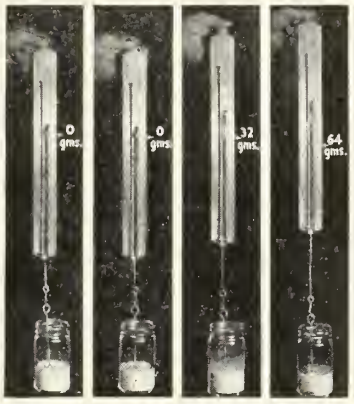
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[1] Morse and Talbott, Diseases of Nutrition and Infant Feeding, pgs. 214, 215.

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—Dr. A. C. Sheets, a member of the Middletown Board of Health for several years, has resigned.

—Dr. Thomas W. Mahoney, connected with the State Department of Health, Division of Communicable Diseases, since 1920, has been appointed health commissioner of Medina County, succeeding Dr. R. L. Mansell.

—Dr. W. H. Burns has been appointed health commissioner of Alliance, succeeding Dr. Earl Musselman. Dr. Burns served as health commissioner for eight years previous to resigning the office thirteen years ago.

—The Ross County Shrine Club has voted to equip and maintain a room for crippled children at the Chillicothe Hospital.

—The nursing school at St. Joseph's Hospital, Lorain, has been affiliated with John Carroll University, Cleveland, student nurses receiving their academic work at the university.

—New equipment for the pediatric department at St. Elizabeth's Hospital, Youngstown, is being furnished by Mr. and Mrs. Thomas E. Farrell, in memory of their deceased son, Edward D. Farrell.

—The new Robinson Memorial Hospital, Ravenna, was dedicated recently with appropriate services.

Officers of the Northern Tri-State Medical Association were guests of Dr. William Donald, professor of medicine, Detroit University, on June 6 at the Detroit Boat Club, the purpose of the meeting being to further the program and selection of speakers for the annual meeting of the association at LaPorte, Indiana, the second Tuesday in April, 1933. Speakers who have been placed on the program are: Dr. Henry A. Christian, Boston, professor of medicine, Harvard Medical School; Dr. Russell M. Wilder, professor of medicine, Chicago University; Dr. Charles A. Elliott, professor of medicine, Northwestern University; Dr. Charles Lukens, Toledo; Dr. Frederick Coller, professor of surgery, University of Michigan, and Dr. Reed M. Nesbit, professor of surgery, University of Michigan. Six additional speakers will be selected later. A clinic for the morning program has been planned. Those who attended the conference were: Dr. Edward B. Pedlow, Lima, president; Dr. G. O. Larson, LaPorte, Indiana, vice president; Dr. Edward P. Gillette, Toledo, secretary; Dr. H. F. Randall, Flint, Michigan, treasurer; Dr. Charles Lukens and Dr. Norris Gillette, both of Toledo, councilors.

The next annual convention of the American Hospital Association will be held in Detroit during the week of September, 1932, it has been decided by the board of trustees of the association.

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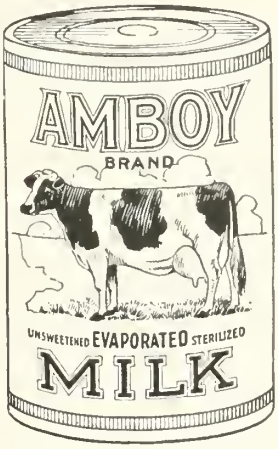
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"Until we realize that what hurts another medical man hurts us, and come to some degree of unity, we shall not gain anything from outbursts of temper or from isolated protests, beyond disappointment and loss of prestige."—Editorial in the *Vancouver Medical Bulletin.*

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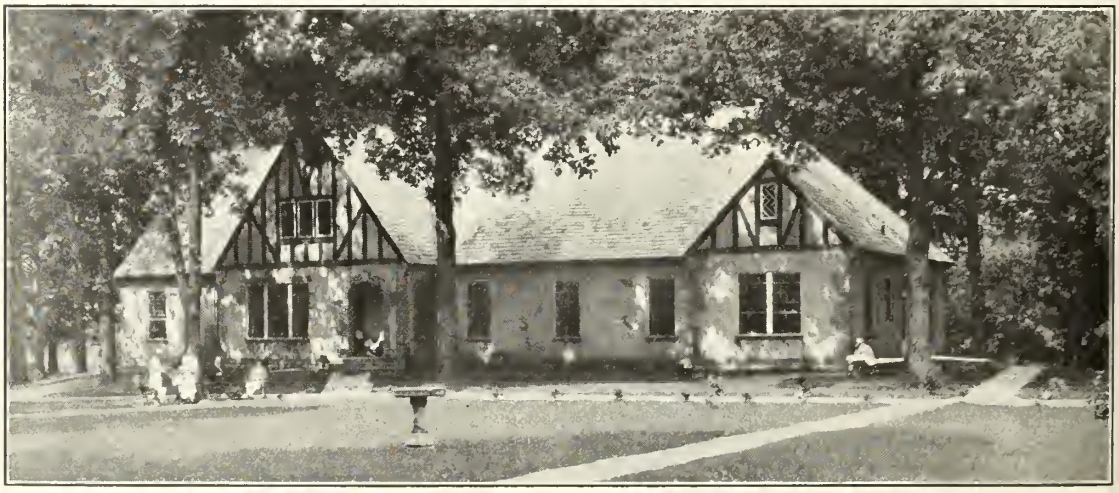
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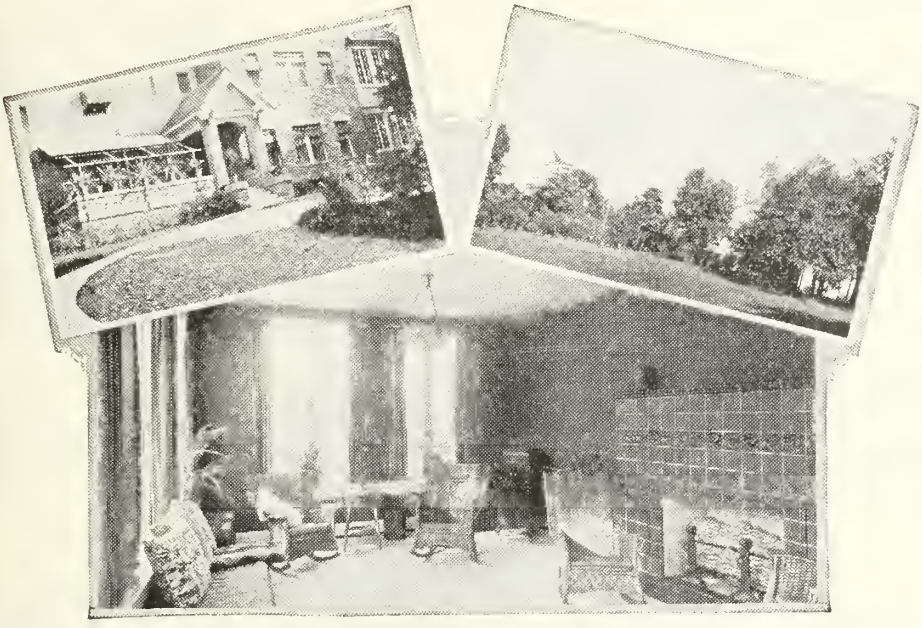
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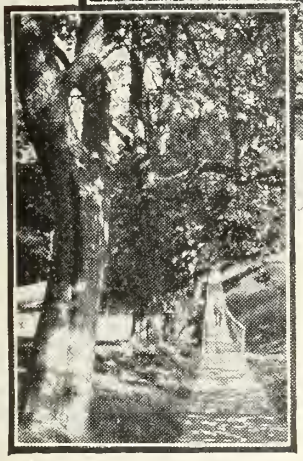
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We certainly want to thank you for bringing our baby along so well, Doctor. It increases our confidence in you as our family physician. Tom has already "said it with dollars", but I wanted to thank you personally, too.

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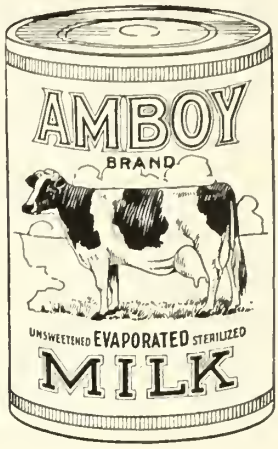
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NEW YORK

PUBLIC HEALTH - SOCIAL WELFARE MEDICAL ECONOMICS and ORGANIZATION PROBLEMS

With Editorial Comment by D.K.M.

Many interesting slants on present-day business and industrial conditions were presented at the recent annual meeting of the Chamber of Commerce of the United States.

Necessity of Organized Cooperation

Judging from post-meeting comments of many leaders in the business and industrial world, the keynote of the conference was struck in the emphasis placed by numerous speakers on the importance of organized efforts, through various trade associations, by business and industrial enterprises toward the solution of vital social and economic questions.

Excerpts from a few of the addresses adequately express the viewpoints of business and industrial leaders generally regarding strongly organized activities in their particular fields.

To quote:

"We are leaning upon the trade association today, as never before, and never has adequate financing and staffing been more important. The association represents a force greater than that of any single company of an industry, no matter how large."

* * *

"Through organized efforts it is quite possible gradually to develop a sounder economic condition to obviate the serious fluctuations on a broad general scale."

* * *

"There has come to most of you, I believe, a strengthening conviction that industry as we classify it today must rely increasingly upon composite planning and genuine cooperation."

* * *

"Unintelligent, wasteful, unsound, unbusinesslike actions can many times be avoided by making promptly available to members of the industry dependable information as to the conditions. The average business man can usually be depended upon to act fairly and intelligently if he is in possession of the proper facts."

* * *

"As individual companies we must * * * increase our moral and financial support of trade associations. We must expand rather than diminish their activity, recognizing that constructive cooperative effort constitutes the most efficient and practical method of meeting many common problems."

* * *

"Let us move in cooperation and according to established principles mutually agreed upon."

* * *

The similarity between the program which these business leaders have suggested and that which medicine has developed is apparent.

The medical profession long since saw the need for strong and active organization. It realized that only through organized effort could it hope to carry on those functions which would be of public benefit and preserve the ideals of the profession. As a result of medical organization, the public as well as the medical profession has benefited.

However, as the foregoing captains of industry and business have emphasized there has never been a time when the need for strong, active and united organization in every field of endeavor has been greater.

Medicine, the same as those in other fields, must be prepared to meet impending problems with its forces organized and with accurate knowledge of the questions at issue.

Medical organization is confronted with important tasks and responsibilities. How effectively it will be able to function depends largely on the amount of interest and cooperation it receives from its individual members.

Many lessons have been learned from the recent session of Congress during the hectic battles over efforts to balance the federal budget and to keep the nation on the path of economic stability.

Economy In Governmental Functions

One of the interesting facts observed by those who followed rather closely events in Washington incidental to the operation of Congress was that while there appeared to be a general opinion that budgets should be slashed and the expenditures of government curtailed, there was little unanimity of opinion as to where Congress should do its financial trimming.

In other words, individuals, as well as groups representing individuals, were ready and willing

to see Congress start paring budgets and curtailing services providing it did not disturb bureaus or services in which they were interested. "Cut the work or service which affects the other fellow but make ample appropriation for the bureau in which I am interested", seemed to be the universal slogan.

We wonder how many Congressmen received as sensible and courageous a letter as the one which an Ohio industrial leader sent to an Ohio member of Congress, in which he said among other things:

"You will not hear a word from us against any cutting of expenses Congress may vote, even if it does hit some service we may now receive, but you will probably receive an increasing amount of correspondence from us if Congress raises taxes without cutting expenses of government to the bone."

As long as special interest groups in large numbers continue to follow the line of least resistance and refuse to recognize the fact that governmental expenditures must be cut all the way down the line, including some of the services which are, from their viewpoint, desirable but not necessarily essential, little will be accomplished in eliminating the extravagances and undesirable functions of government.

The sooner all interests are willing to concede that retrenchment in government means just that, the quicker a lot of the watered stock which has filtered into governmental machinery—local, state and national—will be eliminated.

To a great extent the question resolves itself to whether the savings to over-burden taxpayers shall come through a reduction of actual governmental activities or through the elimination of numerous activities which government has adopted and fostered but which have nothing to do with government. Taking the high cost of non-governmental activities out of the budgets of all governments will do much to solve many current economic problems.

Concerning Medical Advertising

Every so often there takes place a renewal of efforts to interest medical organization in medical advertising campaigns.

Occasionally some county medical society launches such a campaign with worthy objects in view.

There is considerable doubt whether such campaigns are practical or bring returns which justify the expenditure of the necessary funds.

In the opinion of Dr. Morris Fishbein, editor of *The Journal of the American Medical Association*, who discusses the questions of medical advertising and medical publicity in a recent issue of *The Bulletin* of *the American Medical Association*, "not one of these advertising campaigns seems to have accomplished much toward the end sought".

"It is my personal opinion," declared Dr. Fishbein, "that the purchase of space to teach the facts of preventive medicine is not a proper expenditure for a medical organization. Medical education of the public is just as much a function of the press as education in the rules of contract bridge, the technic of golf or the proper training of children. The threat of any newspaper that it will omit scientific news of importance in the field of medicine unless physicians purchase advertising space is an idle threat. Any newspaper worthy of the name must publish scientific news. The vast majority of competent editors are convinced that few other news items are of equal significance at the present day. The newspaper that is dominated in its news columns by its advertising department is on the road to ruin. The question of the publication of newspaper advertisements by county medical societies would appear not to be so much a question of medical ethics as one of common sense in the field of business. From this point of view, the burden is on the promoter to prove that the spending of money for such announcements provides an adequate return to the purchaser of the announcement, or to the public that such announcements are planned to serve."

Since Dr. Fishbein undoubtedly has had an opportunity over a period of years to study carefully the ins and outs of medical advertising, his advice should not be disregarded.

The establishment of extensive public relations is one of the prime activities of medical organization but these relations must be governed by sound professional judgment and good taste.

On Avoiding Emotionalism In a Stormy Sea

Abraham Flexner in a recent address relative to the effect of the economic depression on hospital standards and how those institutions should meet the present crisis declared:

"We are passing through a storm. No one can expect to escape the flash of lightning and the roar of thunder. But storms pass. *In a period of storm, wise navigators take in sail, but they do not jump into the sea.*"

Medicine, like the symbolical navigator Dr. Flexner speaks of, is being tossed about by the storm of hard-times and unrest.

Many ways have been suggested to the medical profession as to how to meet the crisis confronting it. Panaceas by the dozen have been proposed, most of them radical departures from long-established fundamentals which have guided medicine for generations. Numerous attempts have been made to break down the resistance of

the medical profesison toward fallacious and unsound schemes and programs with the plea that they will surely lead medicine out of stormy paths and be a short-cut to the promised land.

Fortunately, medical organization has proved itself a wise navigator despite the stress and strain of the past few years. It has inquired into the various schemes and programs proposed, contemplating making use of those which measure up to the tests of sound and beneficial medical practice. But, it has refused to "jump into the sea". It has refused to become panic-stricken and submerge itself in the backwash of temporary expediency, of destructive and fallacious programs.

The present storm will pass, as predicted by Dr. Flexner, and calm weather will emerge. If we are judicious we can profit by the unpleasant experiences of the present. If we are alert to the present storms we will be prepared to meet new situations and formulate new relationships. To attempt sudden, radical, wide-spread changes now, when calm deliberation is almost impossible, would be fatal. Medicine should continue to adhere to those policies and principles which it knows to be right and time-proven and refuse to be stampeded into following panic schemes and programs, born from emotionalism, and in the last analysis bound to prove detrimental to the public, as well as the medical profession. At the same time we remain "ship-shape" we must keep in mind the port to which we are sailing, even though the course may be somewhat altered.

Propaganda For Socialization

Frequently, the statement is made that America with its rugged individualism will never permit itself to be swallowed up by the tide of social insurance schemes which has engulfed certain European nations, much to their sorrow.

Recent developments lead some observers to doubt this optimistic view unless there is more concerted and energetic activity on the part of those who oppose the substitution of governmental and bureaucratic control of private, as well as public matters, for our present order in which personal initiative and enterprise count for something.

At any rate, it is obvious that exploiters of the idea of fomulating some kind of insurance—compulsory and bureaucratically-operated, of course—for all manner of social and economic problems and situations, have not been idle nor have they failed to take advantage of the present spirit of unrest and the economic situation in furthering their programs.

For example, we read in the editorial column of the mouth-piece of one of the groups which has always been an enthusiastic supporter of variegated governmental socialization schemes, the following comment regarding the endorsement of one kind of social insurance by a special investigating committee comprising representatives from seven industrial states:

"This almost simultaneous fruition of thought in seven states comes not by accident * * *, but to a large extent because a comparatively small group of people scattered throughout the country has, in good times as well as in bad times and over a span embracing three major depressions, persistently propagated the idea of social insurance."

Naturally, the question arises whether or not the public wants this "comparatively small group of people" to continue to presume that it has been ordained to change our social order. Or, is the public willing to undertake the responsibility of thinking for itself and ready to reject summarily the radical proposals which have been offered as a panacea for present-day economic and social ills?

At present, there is little to indicate what the attitude of the public is, or will be, toward these theories which have been "persistently propagated" by an organized minority.

However, one thing is certain: The time has arrived when the forces which stand for sound and practical economic and social principles and for a government operated in accordance with the tenets laid down by wise and far-sighted pioneer American statesmen must realize that a small minority of socially-minded theorists are being courted far too much and too often by a bewildered and befuddled public. The time for compromise and passive resistence has passed. A showdown is inevitable. The result will depend on how intelligently the counter-campaign is conducted and on the courage and energy of those who believe, and rightly so, that America cannot afford to let down the flood gates to the torrent of paternalism now pounding for recognition.

"Expert" Thinking May Be Dangerous

With social and economic conditions in a state of uncertainty; governments—national, state and local—confronted with perplexing problems, and the public mind ruffled by a general spirit of unrest and desire for a change, perhaps without knowing just why, much radical, illogical and impractical thinking is taking place.

Present conditions have undoubtedly been aggravated to a considerable degree by the faulty and misleading propaganda which has been circulated by many so-called investigating groups, having a tendency to stimulate the emotions of fear, apprehension and discontent among the public at large.

Doubtless, many of those who have undertaken to inquire into numerous governmental problems are sincere in their endeavors and are guided by worthy and well-intentioned motives. However, there has been an increasing tendency among many such groups to be too hasty in arriving at their conclusions and to issue unqualified statements based on incomplete data or statistics which are meaningless, if not dangerous, unless properly interpreted and analyzed. In some instances the factor of human psychology has been disregarded entirely.

As a result much of the "findings" of these investigating bodies has been exploited in such a manner as to mislead and misguide the public; give them a faulty picture of the real situation, and add to their bewilderment and discontent unnecessarily.

An insight into this undesirable and fallacious type of "expert" thinking is gained through an analysis of some of the reports on investigations which have been made of medical and health problems, the editor of the *Tennessee State Medical Journal* believes.

Commenting on the report of one such medical investigation, he says:

"Figures are set up to show that a fairly large percentage of people in a certain community did not receive medical care in a certain period of time. These statements of fact are interpreted to mean that the machinery, or mechanism, by which medical services are delivered to people is at fault. Vital facts pertaining to the whole matter are left completely out of the picture. For example, the report does not show that services were sought and not obtainable. The report shows simply that services were not delivered. They leave out of consideration the fact that a fairly large number of people will not avail themselves of medical and hospital services when available, nor do they take into account the fact that a fair number of people regard it as a sin to have a doctor at all."

The same writer cites another example of this type of thinking:

"An old estimate of the value of human life arrived at by some sort of statistical analysis is set up as an actual value of human life in the United States. These values are placed in round numbers. According to figures each human is worth $10,000 and the entire human population in the United States is worth $1,500,000,000,000. The human population includes criminals, the insane, decrepits, in fact, all the people who are a burden to society and not an economic asset at all. No one can dispute this valuation, even though it is many times the value of all other assets combined. I would not dispute the value of it were it three times the amount stated, because from a personal standpoint there are human values that I rate above all of it, even though their economic worth to me is nothing at all. So to use such arbitrary values as a basis for justifying expenditures is utterly ridiculous."

Doubtless, numerous other examples might be cited, with many of which the medical profession is quite familiar.

That these are times of dangerous thinking no one will deny and, as the Tennessee editor points out, "bad thinking is a dangerous thing to follow, no difference who does it".

Occasional Evaluations

Not long ago the editor of the *New York State Medical Journal* asked the members of medical organization in that state to answer the following questions:

"What do people say about your County Medical Society?

"Do they realize that your society is the advisor of the community in public health matters?

"Do the people turn to the County Medical Society for final advice when lay health organizatons propose clinics and consultatons and lecture courses?

"Do the people know that your county has a medical society?"

There is a pertinent suggestion in the foregoing for every county medical society, whether in New York or Ohio or elsewhere.

It is well for every county society to appraise itself periodically in order to ascertain whether or not it is meeting the requirements expected of it. Self-appraisal frequently discloses hidden weaknesses, whether it be of individuals or organizations. Proper remedies for such disclosures are bound to react favorably, not only to the individual county society but to medical organization generally.

As a matter of fact, it would be a good idea for every member of medical organization to quiz himself to see if he is devoting sufficient time and effort toward promoting the activities of his local medical society.

As Dr. A. E. Brant, president of the Mahoning County Medical Society, so aptly said in a recent issue of that society's official publication:

"It has been proven without a doubt that nothing can be accomplished without an efficient organization which will function well under any and all conditions. It is apparent, to some extent at least, that we must cast aside our cloak of indifference and respectable aloofness and get into the game. It does no good in isolated groups to air our grievances, rant about injustices, discuss with dismay the question of state medicine and an unappreciative public, unless to blow off steam. It does do good, however, to give these questions real thought, to honestly analyze them and to act constructively even though the benefits we expect may only come several years hence. If we are wrong let us enter into a program of correction. If the public is wrong let us educate them. How really can we expect our friends and others to do things for us when we make no attempt ourselves, or not even intelligently inform them? An organization in the business world that wants something goes after it. Why can't we, and still maintain our ideals and self-respect. We can."

Fracture of the Neck of the Femur*

Clarence H. Heyman, M.D., F.A.C.S., Cleveland, Ohio

IT was with a considerable degree of hesitancy on my part that I accepted an invitation to present a paper to this audience on the subject of fractures. There are men here who should instruct, rather than be instructed. I have chosen for the subject of this evening's discussion, "Fracture of the Neck of the Femur", not because I profess unusual knowledge of this particular fracture, but because of interest recently stimulated by the investigation of end results in 70 cases treated in Cleveland at Mt. Sinai Hospital. I shall consider the purpose of this paper accomplished if I can leave you with a more optimistic attitude toward fractures of the neck of the femur than you perhaps may have at present. However, one thing is imperative, and that is to treat these cases seriously with great attention to detail.

Prior to the outstanding contribution of Royal Whitman on the subject, fracture of the neck of the femur was generally considered hopeless, and unfortunately this attitude is still held by the majority of general practitioners who, of course, first see the patient. There is a prevailing misconception that an old patient with a fracture of the hip is unsuited for any sort of definitive treatment, because he is likely to succumb to shock or hypostatic pneumonia, and even if he were to live he would be a more or less hopeless invalid permanently. Half hearted attempts at treatment are usually made consisting of supporting the leg with sand bags, hoping that some sort of union will follow. There is another error which should be dispelled. This is the idea that non-union of fracture of the neck of the femur is the result of old age. While it is true that this type of fracture is a common fracture in the aged, it occurs in all decades as shown by our figures. Out of the series of 70 cases studied there were two cases occurring in patients under 10 years of age, and three cases between 10 and 20 years, or slightly more than 7 per cent. Dislocation of the epiphysis of the head of the femur was not included in this series, and if this were included the percentage would be in the neighborhood of 20 per cent. Fifty per cent of cases occurred in patients under the age of 60 years, and surely during this day and age one does not consider himself aged before he reaches the age of 60. As will be shown later, non-union is not the result of old age, but is caused by other factors. It is noteworthy that the highest percentage of non-union in our series occurred between the ages of 40 and 50 years.

There is still a further misconception, namely, that a young adult will recover by bony union when treated by simple traction, or the usual six weeks in a plaster cast. The contrary is true. It is quite certain that an intra-capsular fracture will never unite unless some efficient method is used to insure accurate approximation of the fragments, and to maintain immobilization for a prolonged period of time. A well impacted fracture may possibly prove an exception to this statement, but, in my experience, an impacted intra-capsular fracture of the neck of the femur is extremely rare.

This leads us to still another common error in diagnosis. There is a too ready interpretation of the single roentgenogram as indicative of an impacted fracture. Careful study of the stereoscopic films will usually show an anterior displacement of the distal fragment, to all appearances on casual examination an impaction. I have observed at open operation for ununited fracture that what appeared to be an end to end apposition was really a complete displacement in the anterior-posterior plane. Unfortunately there is no satisfactory technique to secure lateral views on the roentgenogram. While impaction of the intra-capsular fracture may be said to exist rarely, it is commonly present in the extra-caspular fracture at the base of the neck.

In discussing fracture of the neck of the femur it is essential that we adhere to the classification, (1) intra-capsular, and (2), extra-capsular. Any report to be of value must clearly differentiate the type of fracture under consideration. To report that union or good functional result occurs in a certain percentage of fractures of the hip by any particular treatment is of no value whatever, unless the location of the fracture is clearly indicated. Fracture at the base of the neck or through the trochanters (extra-capsular) are almost certain to unite by any sort of treatment. Without disengagement of the impaction or failure to secure a proper apposition of the fragments there will be a malunion with deformity, but bony union practically always follows. On the other hand the transcervical, or intra-capsular fracture, will never unite without some special means used to obtain and hold accurate reduction. Impaction of the fragments in good position, whether natural or artificially induced by the method of Cotton, may prove an exception to this rule; but it is always dangerous to make a diagnosis of an impacted fracture of the true neck. Even with good stereoscopic roentgenograms the position may be deceiving, and a

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loosely impacted fracture is almost bound to slip because of absorption of bone. In general it may be said that the closer the line of fracture to the head of the femur the less likelihood of bony union, and therefore the more urgent is the necessity of efficient treatment.

It is not my intention in this paper to discuss the causes of non-union of fractures in general. My own conviction in the matter is that non-union is caused primarily by separation of fragments, and inefficient fixation. Disturbances in nutrition caused by interference with blood supply plays a role at certain sites. This will be discussed later. Interposition of soft parts has been much overplayed. It undoubtedly does exist when the fragments are separated, and one would not expect otherwise. I believe it is the consensus of opinion among most of us that a moderate disturbance in the blood calcium-phosphorous ratio is of no importance.

Fracture of the neck of the femur, however, presents a peculiar problem. I do not believe that old age in itself has a very important relation to bony union excepting in those patients who do not stand shock well, or who are so debilitated that they can not stand the forced inactivity in bed. In addition to the common cause of non-union, imperfect reduction and incomplete fixation, an intra-capsular fracture profoundly disturbs the blood supply to the proximal fragment. The researches of Lexer and Waldstrom show that the main sources of blood supply to the head of the femur are (1), a vessel entering the upper part of the neck just above the great trochanter and sending a branch to the upper epiphysis, (2), a vessel on the under side of the neck, (3), a small vessel at the internal side of the epiphysis of the head, and (4), a vessel in young children entering through the ligamentum teres, but the latter vessel apparently does not continue after very early childhood. It is apparent therefore that a transcervical fracture interrupts the main source of nutrition to the proximal fragment. If a fragment of bone is intra-articular the opportunity for revascularization through the attachment of surrounding soft parts is greatly reduced. Therefore it is essential that an accurate apposition of the fragments be had in order that there may be an ingrowth of vessels and osteogenic elements from the distal fragment. Phemister describes the changes occurring in the proximal fragment as an aseptic necrosis predisposing to non-union. There is an atrophy of the distal fragment shown by a reduced density in the roentgenogram. The necrotic head can not atrophy, because there is no blood supply to carry off the lime salts, and casts an even and dense shadow as at the time of the fracture. If there is sufficent regeneration of vessels from the distal fragment, and this will be enhanced by absolute fixation, there is an ingrowth of vascular tissue replacing the necrotic marrow resulting in bony union. In non-union there is a gradual erosion of the fragments resulting in a more or less complete absorption of the neck. Since the neck of the femur projects forward and upward from the shaft, solid union must be present before weight bearing is permitted; otherwise the shearing force exerted on the weight bearing fragment will result in coxa vara deformity with a poor functional result.

Treatment of the recent fracture of the neck of the femur, therefore, consists of reduction and in maintaining reduction. The abduction method of Whitman is undoubtedly the most satisfactory closed method to accomplish these ends. Of course, surgical judgment is essential. Whitman describes the method as follows:

"The patient, having been anaesthetized, is placed on a pelvic support with a perineal bar. Two assistants make manual traction on the extended limbs, drawing the perineum firmly against the bar and completely reducing the shortening on the injured side; the surgeon meanwhile lifting the thigh upward, if it is below the plane of its fellow. The limb is then rotated slightly inward, thus completely apposing the fragments. Both limbs, extended and under manual traction, are then abducted to the full limit, on the sound side first, to demonstrate the normal range and to balance the pelvis. When this limit is approached on the injured side, tension on the capsule assures the alignment of the fragments, and forces a resistant contact. A long plaster spica is then applied, which, by fixing the limb in complete abduction, full extension and slight inward rotation, assures the security of internal splinting."

The objection is raised immediately that elderly patients will not stand a plaster spica. Just the opposite is true. The head of the bed is raised one or two feet, and with the injured limb extending over the side of the bed the patient may be propped into a practically sitting position, and be made far more comfortable than the opposite position required for traction. The patient is turned at intervals from side to side and completely over to the ventral position without discomfort or danger of displacement of the fragments. Thus, bed sores and hypostatic congestion may be prevented They may even be transported from one place to another. The apparatus is fool proof, and can not be disturbed.

The period of immobilization again depends on whether the fracture is intra-capsular or extra-capsular. After eight weeks most of the extra-capsular fractures, and surely the intertrochanteric fractures, show sufficient union to discard fixation. The intra-capsular fracture requires at least twice as long fixation in plaster, usually about fourteen weeks. While it is advisable in the extra-capsular fracture to allow only protected weight bearing for two months after the removal of the cast, it is essential not to allow

unprotected weight bearing following intra-capsular fracture until the roentgenograms show unquestioned bony union. Fortunately we have available the Thomas walking splint. This splint, if properly fitted, carries most of the body weight on the tuberosity of the ischium, and prevents displacement and coxa vara. It gives the advantage of physiologic use stimulating union without the risk of displacement. Under no condition, in spite of apparently good roentgenogram appearances, should full unprotected weight bearing be permitted less than nine months from the time of the fracture.

In our series of cases there are 70 with definitely known end results. The percentage of union in all cases, regardless of age, was approximately 70 per cent. Union in patients above the age of 60 years, 17 cases, was secured in 70 per cent. This is difficult to explain, but it would appear that age did not play an important role. An analysis of end results arranged according to ages in decades was published in detail in *Surgery, Gynecology and Obstetrics*, August, 1931.

Although the abduction method of Whitman is recommended it is realized that the percentage of non-union still remains uncomfortably high. Open surgical attack is therefore being proposed for the fresh case, or the one which is not uniting promptly. It is too early to state just what the outcome of these methods will disclose, but apparently they show more impressive results. One of these methods is that of Albee, who, in all cases in which union has not been secured by closed methods in three months, believes that a vascular conducting medium, extending from the great trochanter to the proximal portion of the anemic neck and head, should be supplied by means of an accurately fitting fresh autogenous tibial bone-graft peg. The other operative method is the method of Smith-Petersen, who after an open accurate reduction of the fragments employs a specially devised three-flanged nail driven from the trochanter across the line of fracture well into the proximal portion of the neck and head fragment. The proximal and distal fragments are firmly impacted while under direct observation, Hey Groves proposes a pegging operation in certain selected cases. The hip joint is opened, the head dislocated and made to fit accurately to the neck by means of a beef-bone peg introduced through the proximal fragment, or head, into the neck towards the trochanter. This operation, of course, involves complete removal of the head of the femur and quite likely would have a limited application because of shock. Cotton for years has advocated artificial impaction by a closed method, and continues to use this method in conjunction wth the long plaster spica of Whitman.

TREATMENT OF NON-UNION

The central bone peg operation of Albee is likely the most familiar method to you, and the details of the operation will not be described here. Briefly, it consists of a resection of the fibrous elements between the fragments in order to obtain fresh bony contact, and the insertion of a living dowel bone peg through the trochanter into the neck. Unless one is familiar with surgery about the hip joint, and has the necessary equipment and mechanical ingenuity, I would not advise its trial. It is a difficult operation and requires careful selection of cases. It should not be done in the aged, or in cases where there is a marked absorption of the neck of the femur. Albee, in a paper before the American Medical Association in 1925, stated that the bone peg operation was indicated in only 10 per cent of cases, and that a reconstruction operation was the operation of choice in the other 90 per cent. Since a review of his late end results published in 1928 he revised this statement in view of the striking good results observed in the bone peg operation.

The Brackett operation, also proposed many years ago, aims at a reconstruction of the head and distal fragment to secure accurate apposition with a convex surface of the neck fitting into a concave surface of the head. The great trochanter together with its muscle attachments is transplanted downward on the shaft of the femur. Cotton continues to advocate the Brackett operation as the method of choice, while Albee and Henderson are the chief advocates of the bone peg operation.

The chief objection to both of these operations is that a good result depends on bony union at a region where osteogenesis is at a low grade, and requires the prolonged after-treatment of the fresh fracture. To overcome this objection Whitman again has made an important contribution, the reconstruction operation. Here a good result does not depend on bony union. The head of the femur is excised and discarded. The great trochanter together with its attached muscles is transplanted downward on the shaft as in the Brackett operation, with the neck of the femur articulating in the acetabulum allowing a good range of motion with stability. Fixation in plaster is necessary only for a sufficient time to obtain union of the transplanted trochanter, and the patient is allowed unprotected weight bearing at the end of six weeks. This operation is recommended particularly for patients of more advanced age, and in cases where there is a marked absorption of the neck. It is quite likely that the Whitman reconstruction operation will give more satisfactory results in the hands of most of us.

SUMMARY

While no ideal treatment has as yet been presented, the Whitman abduction treatment is believed to be far superior to all other methods.

The method of Smith-Peterson*, artificial impaction with fixation by means of his special three-flanged nail, is still on trial, and his end results are awaited with interest. The Whitman method is applicable to all ages, and without question is the method of choice in the aged, in spite of the erroneously prevailing notion that elderly patients can not stand a plaster spica. Unless a pegging operation is done, it is the only method whereby the fragments can be properly apposed and held. It is believed that non-union is caused chiefly by inaccurate reduction, inefficient fixation, and not sufficiently long fixation, although the peculiar distribution of nutrient vessels to the head of the femur is undoubtedly a most important factor. Extra-capsular fractures or fracture through the trochanters is not a particularly difficult problem, as union occurs in practically every case. However, a malunion is to be guarded against, and again may be prevented by the abduction treatment.

*Smith-Petersen reported end results of 24 operations with 75 per cent bony union in the Archives of Surgery, November, 1931.

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Jaundice: Its Clinical Aspects*

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JAUNDICE constitutes a clinical sign, and is the result of an increase of bilirubin in the blood serum so that it is diffused through the body tissues. Bilirubin is an iron-free hematin pigment derived from the destruction of erythrocytes by the cells of the reticulo-endothelial system, which are collected largely in the bone marrow, the spleen, and the liver. The pigment is normally present in the blood in a concentration of from 0.5 to 2.0 milligrams for each 100 millilitres of serum, and is separated from the blood stream by the hepatic cells, and is excreted in the bile. van den Bergh discovered that the bilirubin in bile gave a direct reaction when treated with the diazo reagent, whereas, the reaction of the pigment in the blood serum is indirect, alcohol being necessary to bring out the purplish color. It has been suggested that the bilirubin molecule is changed in passing through the hepatic cell; perhaps it loses something which may be protein.

The jaundice present in a number of diseases such as malaria, typhus fever, typhoid fever, leukemia, and certain tropical diseases, is an occasional and incidental sign, and is overshadowed by the findings pertinent to the disease, whereas, the jaundice under consideration occurs as the outstanding and often the initial sign in a group of diseases. McNee has clearly described the mechanisms by which this type of jaundice is produced. There may be: (1) an increased rate of destruction of erythrocytes with an increase in the production of bilirubin; (2) an obstruction to the outflow of bile so that bilirubin is reabsorbed by the blood stream. The obstruction may occur in the liver and is known as an intrahepatic jaundice, or it may occur in the common or hepatic duct and is known as an obstructive jaundice.

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HEMOLYTIC JAUNDICE

Hemolytic jaundice is a disease characterized by an over-production of bilirubin due to an increased rate of destruction of the erythrocytes. The disease has a tendency to recur in the same family, and usually manifests itself before the fourth decade of life. The jaundice usually is not intense, the serum bilirubin rarely being more than 10 mg. for each 100 ml. of blood serum. Since the pigment has not passed through the hepatic cell and been reabsorbed, the van den Bergh reaction is indirect, but uncomplicated cases having a direct reaction have been recorded. There are usually no significant symptoms in an uncomplicated case of hemolytic jaundice. Since there is no obstruction to the flow of bile,the stools have a normal color, the urine does not contain bile and is not highly colored, and urobilin is present in the urine. The spleen is enlarged and usually it is palpable. There is a moderate to severe grade of secondary anemia present, and a study of the blood cytology shows a high percentage of reticulocytes and many microcytes. The fragility of the erythrocytes is increased. These characteristic findings enable one to readily diagnose an uncomplicated case of hemolytic jaundice. However, more than one half the cases have a complicating common duct stone according to a series reported by Giffin. If these stones are large enough or numerous enough to cause periodic obstruction of the common duct, the findings due to the obstruction are prone to mask the underlying hemolytic jaundice. The occurrence of biliary colics, light to clay colored stools, dark urine containing bile, and a direct van den Bergh reaction will indicate a common duct stone. The treatment of hemolytic jaundice is splenectomy, which effects a marked improvement in the disease, and usually effects a complete cure.

INTRAHEPATIC JAUNDICE

Catarrhal jaundice is the most frequent type of intrahepatic jaundice, and is also the most frequent type of all jaundice with the exception of icterus neonatorum. Catarrhal jaundice is probably the result of a mild toxic disturbance of the hepatic cells. It is usually a self-limited disease and complete anatomical and functional restitution occurs. However, Eppinger has shown by biopsy that catarrhal jaundice may progress to cirrhosis. Although catarrhal jaundice often simulates an epidemic in its occurrence, it is rather unusual for more than one member of a family to be afflicted at the same time. The sex distribution is about equal, and the disease may occur at any age from childhood on; its occurrence in a man 71 years of age has been reported. The disease runs its course in from two to eight weeks, depending on the severity and extent of the hepatic injury. One or more of a number of prodromal symptoms including malaise, rheumatic aches and pains, headache, anorexia, nausea, vomiting, and fever usually precede the jaundice. The jaundice increases in intensity to a peak and then gradually subsides until it disappears. During the rise there is a diminution in the flow of bile which varies according to the severity of the disease. There may be a total absence of bile reaching the duodenum, if the process is very severe. The stools will be light colored to acholic, duodenal siphonage will show a decrease or absence of bile, the urine will contain bilirubin and will be highly colored, and urobilin is present unless there is no bile reaching the duodenum, in which case it will be absent. The concentration of the serum bilirubin will show a rising curve until the peak has passed, and then a falling curve will be present. The van den Bergh reaction is direct throughout the course of the disease.

Catarrhal jaundice may be differentiated from acute and subacute yellow atrophy by the absence of high concentrations of the serum bilirubin, which is usually less than 25 mg. for each 100 ml. of serum in cases of catarrhal jaundice, and by the absence of signs of hepatic insufficiency. However, it is often difficult to differentiate between catarrhal jaundice, when it occurs in a patient who is in the cancer age, and a beginning obstruction of the common duct due to a carcinoma of the head of the pancreas. It may be necessary to observe the patient for four to six weeks by which time the jaundice will have begun to subside if it is a case of the former, and the jaundice will be increasing if it is a case of the latter.

The treatment of catarrhal jaundice is designed to protect the liver by forcing fluids and giving a diet of carbohydrates, with fats and proteins largely eliminated. This is reinforced with intravenous administration of one to three litres of a 10 per cent glucose solution in the more severe cases. Pruritis is often present and causes the patient to complain bitterly. The most satisfactory relief is obtained from calomel, one to two grains a day, for two to four days a week, given in divided doses of one-fourth to one-half grains. In the more obstinate cases diathermy, applied generally, will usually give relief, but its benefits are of short duration. After the peak has passed and the serum bilirubin is falling a choleretic may be given to hasten the disappearance of the jaundice. Decholin (sodium salt of dehydrocholic acid) is the preparation of choice, and according to Wakefield and Powelson, it is capable only of flushing out the biliary tree.

Acute and subacute yellow atrophy of the liver mainly differ in tempo, and will be considered together. Beaver and Robertson have reported the pathological changes in the liver due to cincophen poisoning, and demonstrated that the hepatic lesion closely, if not exactly, duplicated the lesions of acute and subacute atrophy and toxic cirrhosis of the liver produced by other causes. The changes in the liver depended upon the severity and completeness of the initial injury, and terminated either in early death, or were prolonged to a chronic cirrhosis. The pathological changes were characterized by more or less rapid necrosis and autolysis of the parenchyma and resulted in atrophy. Since the connective tissue stroma had not been injured it did not proliferate, but because of the atrophy it was relatively increased. Predicated on the duration of life following the initial injury, there was regeneration of the parenchyma from the hepatic cells which had escaped the initial injury. This regenerated tissue was extremely irregular and patchy.

Acute and subacute yellow atrophy are not manifested clinically until there is enough hepatic destruction to cause the characteristic signs of hepatic insufficiency, but the true nature of the condition may be suspected if there is a history of the use of cincophen, or other drug, known to be toxic for the liver. The early signs and symptoms of acute and subacute yellow atrophy, except in the more fulminating cases, may simulate those of catarrhal jaundice, and it is only when the patient is more febrile, has persistent nausea and vomiting, becomes drowsy, lethargic, delirious, and finally comatose that the true nature of the condition is manifest. As the disease progresses the jaundice deepens, the serum bilirubin early rises above 25 mg. for each 100 ml. of serum, the van den Bergh reaction is direct, and bile may, or may not, reach the duodenum.

Although the prognosis is extremely grave once the signs of hepatic insufficiency have become manifest, an occasional patient has survived the initial injury. The treatment is designed to protect the liver as much as possible by glucose and fluids. The etiological agent should be promptly removed if it is known. A preventive

measure which is of much importance is the exercise of constant care and vigilance for any untoward symptom when using cincophen, and the drug should not be used to relieve rheumatic pains which may be the prodromal symptom of a catarrhal jaundice, as the liver is already affected by a mild toxic disturbance.

There are a number of other diseases of the liver which occasionally cause jaundice. Biliary, or icteric, cirrhosis of the liver usually causes jaundice, but the disease is extremely rare except as it occurs as secondary to an obstruction of the common or hepatic duct. Portal, or ascitic, cirrhosis may cause jaundice in its terminal stages, but rarely does it do so before a definite ascites and collateral circulation have indicated the correct diagnosis. Carcinoma of the liver, either primary or secondary, ecchinococcus cysts, and other diseases may cause jaundice if the lesion is extensive or strategically located. However, there will be other signs to indicate the true diagnosis.

OBSTRUCTIVE JAUNDICE

Obstruction of the common or hepatic duct is the third main cause of jaundice. The obstruction may be caused by gall stones, tumors of the head of the pancreas, or stricture. Pressure on the common duct from without, viz. tumors of the right kidney, stomach, and enlarged cystic duct nodes, may cause jaundice, but they are conditions which are rarely of practical importance.

Stones in the common duct are usually secondary to stones in the gall bladder. Judd has found in a series of cases, that stones were present in the common duct in approximately 10 per cent of all cases having gall stones, and that 75 per cent of common duct stones had caused jaundice, while 25 per cent had not caused jaundice. The history of cases of jaundice due to common duct stones is usually quite typical. The jaundice is intermittent and occurs in attacks unless the stone is impacted in the ampulla of Vater. The depth and duration of the jaundice during an attack varies widely. Pain is usually associated with the attacks, but Weir and Partch have reported a series of cases in 10 per cent of which the jaundice was painless. They found that the pain was a more or less typical biliary colic in 80 per cent, while in about 10 per cent it was boring in character, located in the upper abdomen, and not severe enough to require morphine for relief. There is often a history of cholecystitis, indicative of a background of gall bladder disease. During, and for a varying length of time after an attack, the serum bilirubin is higher than normal, the increase varying with the individual patient and attack, and the van den Bergh reaction is direct. The flow of bile into the duodenum is diminished or may even be absent, with the result that the stools are of a lighter color or are acholic. A large number of patients sooner or later develop a complicating cholecangitis, and chills and fever occur with the attacks. Judd has reported cases of common duct stone in which recurrent chills and fever, with and rarely without jaundice, were the only symptoms of the attacks.

During the time the patient is jaundiced there is bilirubin in the urine, and urobilin is present unless the obstruction is complete, in which case it is absent. Between the attacks the patient has no symptoms with the exception of a more or less troublesome qualitative food distress. The serum bilirubin is within normal limits unless the process has become complicated by a secondary biliary cirrhosis; the van den Bergh reaction is indirect as a rule, but it may be direct even when the serum bilirubin is normal. Between the attacks there is a free flow of bile into the duodenum, the stools are normal in color and there is no bilirubin in the urine.

The differential diagnosis of common duct stone may be quite difficult. As mentioned above, the possibility of an underlying hemolytic jaundice must always be kept in mind. In cases of cholelithiasis uncomplicated by a common duct stone, the colics are frequently accompanied by jaundice. Hartman has reported a series of 207 such cases, and in only 41 of them could a common duct stone be demonstrated at operation. In cases of cholelithiasis the jaundice is not as intense, and usually disappears in a few days, whereas it is more prolonged and intense in cases of common duct stone. At the time of cholecystectomy it is advisable to open and explore the common duct, when a suggestive history is present. Another group of cases of common duct stones which may be confusing are those in which the stone is painless. If there is not a history of previous attacks, and if there are not the symptoms of a cholecangitis, it may be necessary to observe the course of the attack. If it is a case of catarrhal jaundice or a case of common duct stone, the jaundice will begin to subside in from three to six weeks. When the jaundice has cleared entirely, cholecystography may prove of value by revealing gall stones, which would point to a common duct stone. Whereas, if the serum bilirubin continues to rise, there is probably a tumor of the head of the pancreas obstructing the common duct, or there is a stone which is firmly impacted in the ampulla of Vater.

The treatment of a common duct stone is its surgical removal, and the selection of the optimum time for the operation is of utmost importance. The patient should be given a diet consisting largely of carbohydrates with restriction of fats and proteins, and the liver should be protected by forcing fluids and by giving intravenous glucose solution. Determination of the serum bilirubin at two to four day intervals will show whether the curve is rising or falling, and will largely determine the optimum time for operation. Unless there is a definite reason for not

waiting, it is advisable to delay surgery if the serum bilirubin is rising, and await its maximum drop, if it is falling. The coagulation time of the blood should be determined at two to four day intervals, and surgery should be deferred if it is prolonged. A course of calcium chloride, given intravenously, may be used in an attempt to shorten the coagulation time, and its use for three consecutive days prior to operation is an advisable precaution. Whole blood transfusion is an efficacious method of shortening the coagulation time when calcium chloride fails, and is of special value in combating hemorrhage. In any event, surgery is to be postponed in the presence of recently formed petechiae, or other evidence of hemorrhage.

Tumors of the head of the pancreas which impinge on the transpancreatic portion of the common duct, are the next most frequent cause of obstructive jaundice. The tumor may be either carcinomatous, inflammatory, or benign, and since surgeons justly refuse to do a biopsy, because of the danger from uncontrollable hemorrhage and pancreatic fistulae, their relative incidence must be based on the gross appearance of the tumor, as autopsy statistics are meagre. The most frequent type of tumor is the malignant one, the next most frequent type is the inflammatory tumor, and the benign tumor is uncommon. Because the tumors are most frequently malignant, the age incidence is in the fifth and sixth decades, and rarely is it under forty years. The onset of the jaundice may be preceded by some weight loss, variable degrees of secondary anemia, and a vague indigestion. The onset was painless in over half the cases reviewed by Weir and Partch, and when pain did occur it was mild and of a boring character, and was located in the epigastrium, right upper quadrant, or lumbar region. However, I have seen cases in which the onset of the jaundice was accompanied by typical biliary colics which required morphine for relief, and in which, later exploration failed to reveal a complicating common duct stone.

Later in the course of the disease, the occurrence of pain is frequent, and it is often very severe, and it is located most often in the back. It is in the cases of obstructive jaundice due to tumors of the head of the pancreas, that Courvoisier's law operates, and a gall bladder that is definitely palpable has considerable diagnostic significance. As the tumor progressively pinches off the common duct, the jaundice gradually deepens, the flow of bile decreases, the stools become progressively lighter in color, the serum bilirubin rises and the van den Bergh reaction is direct, bile appears in the urine in increasing amounts, and the urobilin steadily decreases. When, as eventually occurs, the obstruction is complete, the stools are acholic, the serum bilirubin tends to maintain a fixed level, and urobilin disappears from the urine. It is an axiom with tumors of the head of the pancreas, that once the common duct has been pinched off, the obstruction never abates. This is essentially a reliable rule although exceptions have been reported. These may probably be explained on the basis that the obstructing lesion was inflammatory, and as the process subsided the obstruction was relieved. However, in the event of a fall in the serum bilirubin, the hemoglobin and erythrocyte count should be checked, as a concealed hemorrhage may have occurred, and bilirubin and blood have been poured out the same hole.

As mentioned above, it is usually necessary to observe, for a period of four to six weeks, patients over forty years of age having a painless jaundice, in order to differentiate between a tumor of the head of the pancreas and catarrhal jaundice. It may be impossible to differentiate, prior to operation, between a tumor of the head of the pancreas and a painless common duct stone that is impacted; and between a tumor of the head of the pancreas whose onset is accompanied by biliary colics, and a common duct stone. But fortunately the treatment is surgical in either case.

The treatment of tumors of the head of the pancreas is a surgical procedure designed to short-circuit the biliary tract. This may be accomplished by an anastomosis between the gall bladder, or the common duct, and the stomach, or the small intestine, depending upon which seems to be the most feasible in the individual case. Such a procedure will relieve the obstruction, the jaundice and its symptoms, and the pain to a greater or lesser degree. It will also remove the danger of secondary damage to the liver. The tumor, whatever its type, could not be resected safely, and, since carcinoma in this site often grows slowly and metastasizes late, many years of wellbeing may follow the relief of the obstruction, while if the tumor should be inflammatory or benign, the operation is essentially a cure. The pre-operative treatment is the same as that outlined for common duct stones with one exception. Since the obstruction will almost never let up spontaneously, the serum bilirubin will not fall unless a hemorrhage occurs. Hence it is advisable to defer operation with a rising curve until a fixed level has been reached, if the patient's condition will permit the delay.

Stricture of the common or hepatic duct is the third main cause of obstructive jaundice, and may be either congenital, benign, or malignant. Congenital strictures are quite rare, and if they are complete death ensues soon after birth, unless the obstruction is successfully short-circuited by surgical means. If the stricture is incomplete it is not incompatible with life, and the patient will give a history of jaundice, usually intermittent, dating from infancy. Surgery is the proper treatment in these cases. Congenital strictures must be differentiated from icterus

neonatorum, the mild transient attacks of jaundice so frequent in new born babies, the cause of which is unknown.

Benign strictures of the common duct are much more frequent than malignant strictures. Benign strictures practically never occur except following gall bladder surgery, and it usually follows a cholecystectomy and seldom a cholecystostomy. It is the result of direct surgical trauma to the common duct at its junction with the cystic duct, or it is due to the secondary contraction of scar tissue. Choleangitis in its severest form is the usual complication of this type of stricture, and plays an important role in the formation of the stricture, as well as to seriously impede its successful surgical repair. The stricture may obstruct the common duct during the post-operative course with the formation of an external biliary fistula, or it may develop gradually and result in obstruction after many months of wellbeing. However, obstruction will usually occur within a year of the operation if a stricture is present. Like jaundice due to tumors of the head of the pancreas, the onset of the jaundice was painless in over half the cases of stricture reviewed by Weir and Partch, and when pain was present it was mild and of a boring or aching character. However, in a few cases, the jaundice was heralded by typical biliary colics. Unlike tumors of the head of the pancreas, the jaundice resulting from stricture is usually intermittent, and the attacks are accompanied by severe chills and fever. The serum bilirubin will fluctuate as a rule, the van den Bergh reaction is direct, and the color of the stools will vary with the obstruction in the flow of the bile. The choleangitis soon extends up the biliary tract into the liver, and early and extensive damage results. Biliary cirrhosis is evident early in these cases.

The differential diagnosis between stricture and common duct stone is often extremely difficult. A patient, whose gall bladder containing stones has been removed, in whom jaundice develops during the post-operative course, may have a mechanically formed stricture, or a stone which escaped detection at the operation. In such a case it is advisable to reoperate as soon as the patient's condition permits, and correct the condition which is found. When a period of months or years has intervened between gall bladder surgery and the onset of jaundice, it may again be impossible to make an accurate pre-operative diagnosis. If the interval is less than a year, the odds favor a stricture; if the gall bladder was drained and contained stones, the odds favor a stone; if the gall bladder was removed, the odds favor a stricture, especially if stones were not present; if the jaundice is associated with colics, the odds favor a stone; if the jaundice is painless, the odds favor a stricture; if there are associated chills and fever, the odds favor a stricture; and if the jaundice is not intermittent, tumor of the head of the pancreas must be considered.

Benign strictures are amenable only to proper surgical procedures, which should be instituted after the pre-operative preparation, outlined above, has been carried out. When a freely draining external fistula is present, decholin may be used to flush out the biliary tree. This will tend to prevent a choleangitis, and will be of value in combating the infection if it is present. The surgical attack is varied, and the surgeon must select the best method for the individual case. Suffice it to say, that strictures of the common duct are among the most trying and disheartening cases a surgeon can face.

Malignant strictures of the common duct due to carcinoma of the head of the pancreas have been considered. Those due to primary carcinoma of the common or hepatic duct, or due to direct extension of a malignancy which is primary in the gall bladder, are rare. It is impossible to make a definite clinical diagnosis in these cases, unless a hard, nodular tumor is palpable in the gall bladder area. It is possible to make a diagnosis of obstructive jaundice, however, and exploration is indicated if the patient's condition permits. Again the surgeon will select the procedure best suited for the individual case.

SUMMARY

McNee's classification of the causes of jaundice is discussed, and the differential diagnosis is considered. The treatment of the various types of jaundice is outlined.

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A new filing and record system has been installed in all the state mental hygiene institutions of Illinois, whereby it will be possible to keep a complete and authentic record of every patient, including data on the patient previous to admission and information on his progress while in the institution.

The 1932 annual meeting of the American Association of American Medical Colleges will be held in Philadelphia on November 14, 15 and 16. The Benjamin Franklin Hotel has been designated the headquarters hotel.

Narcolepsy*

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THE recent increase of interest in the various disorders of sleep and their causal mechanisms is a direct result of the epidemic of influenza and encephalitis of 1918. So frequently were the attacks of influenza associated with morbid somnolence that this previously unrecognized clinical entity became known as encephalitis lethargica. Although the name "sleeping sickness" is still widely used we now know that epidemic encephalitis in the acute stage is not always accompanied by pathologic sleep nor pathologic wakefulness. In many patients presenting such a well recognized sequela of encephalitis lethargica as Parkinsonism there is no history of an illness resembling the acute phase of the disease.

Whether encephalitis lethargica existed prior to 1917 is still disputed but no one can deny that there has been a marked increase in the various forms of sleep disturbances since the epidemic of 1918. Of these disorders of sleep we are here concerned with morbid somnolence which Levin[1] has described as "the untimely occurrence of periods of more or less natural sleep". Since this symptom is met in a wide group of clinical conditions it seems advisable to mention the more common ones in which morbid somnolence is a conspicuous clinical feature.

Organic diseases of the brain such as arteriosclerosis, tumor, abscess, multiple sclerosis and epidemic encephalitis are often accompanied by an abnormal desire to sleep. The same tendency is seen in the diseases of the meninges and following head injuries with trauma to the cranial contents. In these latter cases the drowsiness is due to interference with the normal cerebrospinal fluid circulation and to increased intracranial tension. Lumbar drainage, when indicated, may cause the somnolence to disappear in meningitis and other cases with increased intracranial pressure.

Pathologic sleep exists as a symptom in certain disorders of metabolism. In diabetes, liver dysfunction, toxic and fatigued states we expect to see increased demands for sleep. The endocrinopathies, such as hypothyroidism, gonadal insufficiency, pituitary dysfunction, are also related to the symptom. Somnolence occurs early in the acute febrile diseases and is seen in increasing degree in the toxemias and chronic wasting diseases. Certain drugs cause the untimely occurrence of periods of more or less natural sleep.

Narcolepsy is a definite symptom complex belonging to the group of diseases which produce disorders of sleep. It has been called Gélineau's syndrome since Gélineau published his monograph "De la Narcolepsie" in 1881. Westphal had described the condition in 1877, but he failed to recognize it as a clinical entity and Gélineau gave the symptom complex the name narcolepsy in 1880 when he presented his first case.

Narcolepsy or Gélineau's syndrome is characterized, first, by attacks of almost irresistible sleep occurring without apparent cause and, secondly, by recurring periods of sudden and peculiar weakness of the entire motor system during emotional states such as laughter. During this period of uncontrollable loss of muscular tonus the patient may fall and receive serious injury although the blockage of tonus is seldom accompanied by any disturbance of consciousness. This second phase of the syndrome is known as the cataplectic attack or cataplexy.

Some conception of the uncontrollable desire to sleep can be gained from the following instances. One of Spiller's[2] cases, a locomotive fireman, would fall asleep while holding to the grabirons of a train said to be moving at a speed of about 70 miles an hour. Levin[1] reports a case who would go to sleep while riding a bicycle. Case 2 of this report fell asleep while standing and taking a verbal inventory in his store. Case 3 claims to have wrecked eight cars by falling asleep. Practically all of the cases give a history of falling asleep while eating and many report going to sleep while talking and walking. It is interesting to know that falls seldom occur when the sleep comes on during walking and that a light touch is usually sufficient stimulus to bring them back to consciousness.

The expressions "paralyzed by fear" and "he laughed until he was weak" seem to have some relation to the cataplectic attack. Evidently there is a relationship between the emotions and muscular tonus even in normal individuals. In cataplexy the paralysis of muscular tone is extreme. Wilson[3] first observed that the deep reflexes disappeared during the attack, that the corneal reflexes were absent and that a positive Babinski was obtained. The reflexes returned in a few minutes following the attack which usually lasts from a few seconds to several minutes. Although Wilson's patient was entirely helpless during the attack he recalled every detail of the examination made while he was toneless and apparently unconscious.

Such a mild emotional stimulus as meeting a friend or seeing a pretty dress in a show window has served to excite an attack. The most common cause is the act of laughing which is mentioned by practically every case as the chief

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cause of their weak or limp spells. Drawing a good hand of cards, making a good shot at pool, getting a nibble while fishing and sinking a long putt are all mentioned as having been the cause of attacks by the cases reported in this paper. Case 3 complains of becoming absolutely limp just before the crisis of the sexual act although consciousness was not affected. Upon making an exceptional drive while playing golf, Case 2 almost invariably felt a weakness in his toes and knees which quickly extended to his body so that he would fall helpless. He trained a caddy to rush up and support him as soon as he threw his club which was the signal that his legs were giving way.

Considerable confusion exists in the literature because of the use of Gélineau's term narcolepsy in connection with cases of pathologic sleep which do not present the cataplectic phenomenon. There is some justification for such usage. The two phases are independent although it has been observed that an effort to delay a desire for sleep may precipitate a cataplectic seizure in some patients. Again the cataplexy is frequently followed by a period of somnolence. It is worth noting that Case 3 of this report had the attacks of sleep for several years before the appearance of the first cataplectic attack. Accumulating histories bear out this fact but it is rare to find the cataplexy antedating or without the morbid somnolence. Much confusion could be avoided by speaking of narcolepsy and narcolepsy with cataplexy or Gélineau's syndrome.

Although Gélineau's monograph attracted considerable attention less than 25 authentic cases appeared in the literature between 1880 and 1920. Levin[1] collected 66 typical cases in the literature up to 1929 and in the same year many additional cases were reported. At the Mayo Clinic[4] 42 cases were recognized in a total registration of 361,602, or one case for every 8,610 admissions between 1919-1928. It is still an uncommon disease.

The increasing recognition of the disease has been attributed by some to the increased interest in the disorders of sleep. That this does not entirely account for the increased incidence is shown by the statement of Kinnier Wilson,[3] the British neurologist, who saw his first case in 1907, and his second case in 1928. Spiller[2] of Philadelphia in 1926 wrote: "A few years ago it was exceptional for a neurologist even with a large experience to see a case of typical narcolepsy." One must accept the conclusion that there is a causal relationship between the recent epidemics of influenza and the increased incidence of Gélineau's syndrome.

The etiology and pathology of narcolepsy are obscure. Until the present time no postmortem studies have been reported on cases of the so-called idiopathic type. The present knowledge of the physiology of sleep would point to the region of the tuber cinereum as the location of the focal lesion responsible for the symptom complex. Injection of calcium chloride into this region in animals produces a deep sleep lasting 30 to 40 minutes while potassium chloride injected in the same location produces overactivity. The conclusion is that the sleep regulation must be controlled by this particular area of the brain between the optic chiasm and the mamillary bodies close to the floor of the third ventricle. Zador[5] has produced cataplexy by injections of a preparation of calcium chloride and urea. Wagner[6] presents clinical evidence that there is a direct relationship between the symptom complex and the calcium balance of the body.

Gélineau considered the condition a neurosis and European writers still cling to this view but emphasize the associated endocrine dysfunctions. They point to the frequent association of obesity, low blood pressure, various disturbances of metabolism and the disorder. Changes in the size and shape of the sella turcica have been reported in many of the early cases.

The relationship of encephalitis is of greatest interest, however. Not only is a history of encephalitis often encountered but we now recognize that the acute phase of encephalitis can occur without diplopia, the somnolence or wakefulness, at least in sufficient degree to attract attention. The extension of a low grade encephalitis and its associated pathological changes upon the infundibulum into the hypothalmus and the region of the third ventricle would seem to offer the best explanation of the probable cause of the syndrome. At the same time the relationship of the pituitary body accounts for the endocrine changes which are so frequently seen in the disease.

CASE REPORTS

The following three cases represent different forms of the disease. The first is a case of narcolepsy without definite cataplexy. The second case is a typical case of narcolepsy with cataplexy, while the third is complicated by a history of severe trauma to the head and demonstrable pathology of the central nervous system.

CASE 1—Female—21 years—single—housework—observed since fall of 1927. Examined June 28, 1930. Last visit January 8, 1932.

Chief Complaint—"Whenever I sit down I go to sleep. Sometimes when I laugh I get a funny feeling in my head and my knees and my arms get weak. I go to sleep eating, on the street cars, every place".

Present Illness—Began in 1924 following a spontaneous abscess on left arm which was lanced and healed slowly. Shortly after this she was given toxin-antitoxin for diphtheria. In a few months complained of being tired and went to sleep at school while writing an examination. By 1926 sleepy spells were more frequent. In 1927 she entered the nurses' course but withdrew because she could not control her desire to sleep while on duty.

In 1929 an examination by an excellent clinic

included negative Wassermann and Kahn, basal metabolism, *X*-ray of skull, etc., and led to the suggestion of chronic encephalitis as a cause of the complaint of drowsiness. Ovarian therapy was recommended and tried.

In 1930 attacks had become more frequent and a short nap no longer relieved the desire for sleep. She could no longer hold a job or drive an auto and would go to sleep in the act of eating.

Personal History—Family history irrelevant. First child, normal delivery. Had measles, mumps, chickenpox, whooping cough. Tonsillectomy at 9 years. Influenza without cranial nerve involvement in 1921 with good recovery. Shortly afterward fell and struck head and suffered frequent headaches for one year. Menses began at 14, irregular until after ovarian therapy in 1929.

Physical Findings—Healthy appearing white girl—movements active; no suggestion of Parkinsonism. B.P. 120/78. Vasomotor instability noted. Thyroid—lateral lobes full and soft. Cranial nerves intact. Deep reflexes active, slight increase in left arm and leg. No tremor. No pyramidal signs. Sensory examination negative.

Diagnosis—In June, 1930, I considered her a case of chronic encephalitis without Parkinsonism. After seeing two cases of narcolepsy early in 1931, I reviewed her case and found her original complaint included "my knees and my arms get weak when I laugh". Final diagnosis—Narcolepsy without definite cataplexy.

Progress—Improvement had been noted for short periods prior to July, 1931, following ovarian therapy, iodides, injections of foreign proteins. August 16, 1931, after two weeks' treatment with ephedrine she wrote "not as sleepy as usual. After a short nap now I feel as rested as I did before after several hours' sleep". September 19, 1931, she reported, "It does not take as much sleep to do me. The medicine seems to be keeping away that funny feeling in my head. I do not get sleepy eating at the table. I am out of work and if I do not get work pretty soon I will have to quit taking the medicine". January 8, 1932, she reported that she had quit the use of ephedrine and was receiving calcium injections for her drowsiness from another doctor.

Comment—This represents the incomplete type or as Wilson describes them "the larval form". After seven years there is little progress in the disease. She has never had a typical cataplectic attack—only weakness in her legs and arms when she laughs. There is no evidence of early Parkinsonism.

CASE 2—Male—46 years—married—business man—examined August 6, 1931. Reported January 8, 1932. Referred by Dr. Ralph S. Licklider.

Chief Complaint—"I fall down the very second anything strikes me funny or thrills me. I can laugh all right. It has to really strike me funny. If I talk cross to my dog I fall down. If I make a good shot at golf I get as limp as the day I was born. My caddy is trained to rush up and support me if I make a good drive or sink a long putt. If I get a fish on the line when I'm fishing I fall right over.

"I get sleepy spells I just can't resist two or three times a day. After 5 to 10 minutes I wake up and feel fine. I have to stop on the way home from the golf course and sleep. Once I drove clear through Circleville and didn't know it. I went to sleep taking an inventory standing up, and the clerks had a big laugh."

Present Illness—Both the limp spells and sleepy spells began about 1926. While playing tag with his daughter he made a daring dash for the goal and felt a thrill at his agility. "Immediately my legs went from under me and I took an awful spill." He attributed this and the sleepiness to "autointoxication due to the fact that I'd driven about 600,000 miles in the four or five years previous". Since 1926 he has gained 50 pounds and feels fine except for the chief complaints.

Personal History—Irrelevant except for history of influenza in 1918 or 1919. Does not recall that he had any double vision at the time, and states that he made a prompt recovery.

Physical Findings—An athletic type individual —B.P. 116/78—pulse regular—heart sounds good. Cranial nerves negative except for oval shaped pupils which reacted and responded fairly well. Deep reflexes and sensory findings were not remarkable. Appearance, station and gait normal.

The Falling Attack—"My friends think it's the funniest thing they ever saw. I've been to at least twenty doctors, four of them in my own family. Some say it's hysteria, others just nervousness, and some think it's epilepsy. I just lose control of my body. Even my fingers become paralyzed and my jaw drops wide open and I'm as relaxed as the day I was born. It starts in my toes, then my legs and on up my body, and I can't stand up at all sometimes. It passes off in a half to three-quarters of a minute. I'm perfectly clear all the time and know exactly what everybody says, but can't move a muscle. There are no ill effects afterward."

Diagnosis—This case represents the typical form of Gélineau's syndrome.

Progress—Ephedrine gr. ¾ b.i.d. or t.i.d. was used daily from August 7, 1931, to December 25, 1931. From December 26 to January 8, 1932, he has omitted the ephedrine. He has had no falling attacks since the first dose of ephedrine. The desire to sleep has been little affected by the ephedrine. Recently he has noticed a weakness in his legs if he awakens suddenly. No untoward effects were noted while taking the ephedrine in ¾ gr. doses b.i.d. or t.i.d. for five months.

Comment—Friends and associates suspected this man of addiction to drugs or alcoholics. Medical opinions varied from hysteria to petit mal. The increase in weight is commonly commented on in the literature and is probably due to disturbed pituitary function. While the ephedrine stopped the cataplexy it had little effect on the morbid somnolence.

CASE 3—Male—23 years—married—laborer—referred July 14, 1931, by Dr. R. J. Secrest. Observation at University Hospital July 14-August 30, 1931.

Chief Complaint—"My head aches and my back aches. I go to sleep eating and right in company. I can put it off 5 to 10 minutes, then I drop right off to sleep. I go to sleep driving an automobile. I went through a bridge one night and never got a scratch. If I just sleep 10 to 15 minutes I'm all right.

"I get weak spells when I laugh. I got heck from the people downstairs for dropping a tub full of water when my wife said something funny and the tub and I both dropped. It's just when I laugh and then I can't do nothing. The first time was about 1926 when some fellows told a funny story and I just rolled away. I couldn't talk or nothing, but I knew they were nudging me and it made me mad."

Present Illness—Began with quinsy in 1923.

Several days after abscess was lanced he noticed a desire to sleep all the time. He describes it as uncontrollable. These have continued since and there has been an associated inversion of the sleep order. "Weak spells" accompanying emotional excitement appeared in 1926 and consist of complete loss of motor control, usually without any disturbance of consciousness.

Personal History—Family history not remarkable except for fact that mother deserted her husband and four children. The patient is a moron. Had quinsy and sleepy spells in 1923. Claims he was a prize fighter in 1925. Was struck over the head with a pop bottle in a dance hall fight in 1926, and "was out of my mind for better than a day". He has scars in the right frontal region where he was struck. Was admitted to the Lucas County Hospital July, 1929, because of "sleeping too much—gets weak when he laughs—inability to walk properly". He was readmitted in May, 1931, and diagnosed narcolepsy at the time of his last admission.

Physical Findings—Inferior looking white male about 25 years old—round, dull facies—appearance suggested Parkinsonism, but gait was peculiar. Speech pseudo-bulbar and increased when tired. Pupils equal, react poorly to light. Eye grounds and visual field normal. Bilateral impairment of cranial nerves, 3, 4, 5, 7, 9, more marked on right. No change in reflexes or movements of arms. Abdominal reflexes absent. Cremasterics active. Patellar, Achilles, Babinski negative. Romberg negative.

Laboratory—Blood Wassermann, blood count, hemoglobin negative. N.P.N. 30 mgm. Urea Nitrogen 11.3 mgm. Creatinine 1.3. Blood calcium 13 mgm. Urinalysis negative. Glucose tolerance fasting 50 mgm.—minimum after 1½ hours of 136.3 mgm.—minimum after 3½ hours of 37 mgm. Basal metabolism—17.7%.

Encephalogram—On July 18, 1931, Dr. H. E. LeFever injected 80 cc. of air after finding a spinal fluid pressure of 10 mm. Hg. He reported "Possibly a slight atrophy of the anterior part of frontal lobe on the right side. Otherwise a normal encephalogram". There is a history of head injury in the right frontal region in 1926.

Observations—Almost daily attacks of sleep were observed and several typical attacks of cataplexy. While being examined he became amused at a remark of Dr. Berg—laughed—speech became slurring and indistinct—he appeared to be unconscious and remained limp and unresponsive to questioning for about three minutes. He awakened in moving his head from left to right and suddenly started. He had only a partial recollection of what was done during the attack. Before the attack his blood pressure was 98/64—during the attack it was 102/52.

Diagnosis—The history of irresistible sleep beginning in 1923 after the quinsy stands out together with the typical falling spells on laughing and justify a diagnosis of narcolepsy with cataplexy. The head injury and boxing may have been contributing factors. The neurological findings indicate an extension of the pathologic process to the brain stem, producing a more complex clinical picture.

Progress—Patient was placed on ephedrine sulphate gr. ⅜ t.i.d. without complete disappearance of the cataplectic attacks and little improvement in regard to sleepiness. With the dosage increased to ¾ gr. t.i.d. the cataplexy disappeared and there was a reduction in the desire for sleep. January 7, 1932, this patient wrote, "What was in them capsules? They done me a world of good. I am not taking them no more because I cannot get them."

TREATMENT

The symptomatic treatment of narcolepsy with ephedrine was first reported by Janota and Skala before the Prague Neurologic Society in June, 1930. Independently Doyle and Daniels[7] of the Mayo Clinic reported their experience with ephedrine in October, 1930. Subsequently they[8] reported their results in a series of six cases. Five were completely relieved of the essential symptoms of irresistible desire to sleep without apparent cause and the relaxation of the muscular system during emotional excitement. The sixth case was markedly improved. So little is understood of the pathological physiology associated with this complex symptom-complex that no attempt has been made to explain the mechanism involved in the therapeutic effect of ephedrine.

In regard to prognosis our present knowledge indicates that narcolepsy is essentially a chronic condition which is seldom accompanied by signs of mental deterioration. Whether the cases who have the post-encephalitic variety will be able to go twenty years without alteration in character as recorded in the so-called idiopathic form remains to be seen. So far there is no observed change in the life expectancy of individuals who have this disease.

The relation of narcolepsy and problems of public safety is evident when one considers the unavoidableness of the sleep and falling attacks. Sufferers from this condition are seldom sick in the usual sense of the word and can see no reason why they should not continue to operate autos and locomotives or carry a hod of bricks a hundred feet above a crowded sidewalk as long as they know enough to find a place of refuge when the desire for sleep overtakes them. However, the establishment of a diagnosis of narcolepsy is certainly sufficient cause for removing an individual from a position endangering the lives of the public. The problem differs very little from that presented by the various convulsive disorders.

SUMMARY

1. Narcolepsy or Gélineau's syndrome is a disorder of sleep characterized by sudden attacks of almost irresistible sleep and recurring periods of sudden and peculiar weakness of the entire motor system during emotional states.
2. The increasing incidence of narcolepsy is due to the recent epidemics of encephalitis.
3. Three cases are presented showing (1) the incomplete or larval form without definite cataplexy, (2) the typical narcolepsy with cataplexy, (3) narcolepsy with cataplexy complicated by a head injury.
4. Treatment with ephedrine sulphate by mouth relieved the cataplexy in Cases 2 and 3, but had little effect on the morbid somnolence in any of the cases reported.

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Treatment of Carcinoma of the Colon by Surgical Methods*

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CARCINOMA, which is the most frequently encountered neoplasm of the colon, is evidently on the increase. This increase, however, is probably more apparent than real. Certainly carcinoma is being recognized more frequently than ever before, and this fact no doubt can be attributed to the increased accuracy of roentgenologic diagnosis and more employment of the roentgenogram as a routine in cases of suspected colonic lesions. That the incidence of carcinoma of the intestinal tract has actually increased in recent years is attested in Hoffman's statistical report for carcinoma for 1930. In the period 1920 to 1929, of all deaths from carcinoma in the country, those from carcinoma of the intestinal tract most pronouncedly increased. Carcinoma of the intestine, excluding the rectum, increased from 7.1 to 9.4 per 100,000, while in England and Wales, during the same period, the corresponding increase was from 6.8 to 13.6. Since less than 3 per cent of carcinomas invade the small bowel the figures given here essentially represent the incidence of carcinoma of the colon.

Surgery remains indisputably the procedure of election in the treatment of carcinoma of the colon, notwithstanding progressive improvement in recent years in the technic of radiotherapy. It is not probable that even the most enthusiastic purist in this field of therapy would advocate employment of radium or deep roentgen therapy for operable cases of malignancy of the colon, above the rectosigmoid juncture, to the complete exclusion of surgery. Surgical removal of the offending neoplasm is but one phase in the treatment of these cases. I am convinced that the successful outcome following resection of the colon, especially in cases of malignancy, depends more on adequate preoperative preparation and measures of rehabilitation than on technical procedures. A considerable number of the patients, perhaps a majority of them, on admission are in a state of lowered resistance; they frequently are anemic, and as a result of obstruction, are dehydrated and desiccated. To increase the general resistance of the patients, dietary and rehabilitating measures are combined with an attempt at decompression of the bowel over a sufficiently long period to reduce materially the virulent infection about the growth and the obstruction caused by it. Frequently transfusions of blood are indicated, and insistence on a greater intake of fluid and a diet high in calories are necessary. Fruit juices, candy, rice, butter, eggs, and so forth, low in residue and high in food value are urged. During this period, decompression is attempted by frequent rectal irrigations with warm saline solution in conjunction with mild purgation.

An additional measure, which I am confident has thoroughly proved its worth, is the employment, as a routine, of a mixed vaccine made of streptococci and colon bacilli, prepared from patients who have succumbed to peritonitis, and administered intraperitoneally. Experience has proved that the optimal time for vaccination is approximately seventy-two hours before operation. A mild local reaction, and a mild to moderately severe general reaction, characterized by malaise, headache, elevated temperature, and pulse rate is manifested over a period of twenty-four hours. In the last four years, this procedure has been carried out in more than 800 cases, and as one agent in the sequence of a number of factors, has undoubtedly aided in a steady decrease in the mortality rate for surgery of the large intestine. Moreover, it has been conducive of smoother and more comfortable convalescence in the majority of instances.

Obviously, controls cannot be furnished for each case in which the vaccine has been employed, since in the last two years practically every patient with a lesion of the large bowel has received such protection against peritonitis. In two preliminary reports, however, Bargen and I have made comparisons between the mortality of patients who received the intraperitoneal mixed vaccine, and those who did not. During 1928, in sixty cases of carcinoma of the colon in which the vaccine was given, there was a mortality rate

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of 5 per cent, whereas in a control group of sixty cases in which there were identical lesions, the mortality rate was 23 per cent. In 1929, 222 cases were reported in which vaccine was given between January 1, and October 1, and fifty-eight cases in which operation was done in the course of these months for similar conditions, and in which the vaccine was not given. Eleven deaths occurred from peritonitis among the 222 cases, representing a mortality rate of 4.9 per cent while of the fifty-eight cases in which vaccine was not given, there were thirteen deaths from peritonitis (22 per cent). This lowering of the mortality rate by 17.5 per cent in this series, while perhaps not attributable entirely to the vaccine, certainly recommended the vaccine as a likely factor.

A question of major importance is determination of the optimal time for exploration. Carcinoma of the colon, as the patients present themselves in the routine of the work is seldom to be considered an emergency condition. The chronic variety of obstruction is the usual one encountered at The Mayo Clinic, although in about 5 per cent of cases acute, fulminating intestinal obstruction is observed. Acute obstruction, of course, must be dealt with as a primary condition, and removal of the offending malignant lesion left to a later day. It may well be that in larger communities this incidence of acute obstruction is somewhat higher, but certainly the relative frequency of carcinoma of the colon which produces acute intestinal obstruction in any community is insignificant, compared to all cases. One-third of the cases of acute intestinal obstruction of adults was found by Burgess to be due to malignant neoplasm of the colon and he concluded that if one can exclude hernia and intussuception, without localizing the lesion, the chances are nine to one that the cause is a malignant growth. It may be added that a vast majority of these malignant growths are in the left half of the colon, and more often than not, at or near the rectosigmoid juncture.

I am primarily interested here, however, with the larger group, that of chronic and acute obstruction, which may be reasonably estimated as including approximately 75 or 80 per cent of all patients with carcinoma of the colon. There are two very definite reasons why this obstruction obtains for lesions of the left half of the colon; namely, the tendency of carcinoma of this segment of the bowel toward stenosis, and the fact that this segment, which has a common origin with the rectum from the hind-gut, likewise exhibits the same characteristic of storing hard, formed fecal materials. Indeed, such a combination of factors readily invites obstruction. On the other hand, obstruction in the right half of the colon is the exception rather than the rule, since this segment manifests the general properties of the small bowel, with which it arises from the mid-gut, and the function of which is digestive and absorptive in character. The greater diameter of its lumen, and the liquid nature of its content, militates against obstruction. Here, the objective of the preoperative measures is to counteract anemia, which more often than not is profound, and toxemia, which may be overwhelming in degree, rather than to combat dehydration, desiccation, and starvation from obstruction.

The propitious time for exploration to be undertaken depends largely on the degree of obstruction present, and on numerous factors that go to determine the physical status in individual cases. Disregard for the fact that virulent organisms have a normal habitat in the large bowel, increasing in number and virulence in certain distinct conditions if obstruction is present, perhaps operates more against successful outcome in any type of mechanical procedure than any other one consideration. Consequently, adequate preoperative preparation of the bowel, consisting of drainage after institution of measures to cleanse the bowel, and routine establishment of a proper diet high in calories in which there is little residue, and which has already been considered along with other rehabilitating measures, increases markedly the chances of satisfactory recovery.

I desire to emphasize the method and the time of decompression. It is naturally assumed that no one would have the temerity to attempt to decompress an acutely obstructed colon by other than surgical methods. To do so would be to invite disaster in a majority of instances. Subacute intestinal obstruction, on the other hand, if it is confined to the large bowel, is well tolerated over a period of several days without altering the blood chemistry, and without the grave prognosis common to cases of obstruction of the small bowel. No particular danger attends postponement of operation in these cases, during which time repeated enemas and mild purgation are instituted, provided the patient is carefully watched, and surgical decompression is instituted immediately if it becomes evident that medical measures have failed. Such measures not only prevent production of acute intestinal obstruction, but in most cases relieve impending obstruction and restore the bowel to a relatively normal physiologic state. Hermann has very conclusively demonstrated that obstruction of the large bowel, which is accompanied by an ulcerative lesion, produces a condition which greatly enhances the permeability of the wall of the colon and thereby enables extravasation of highly virulent organisms out into the adjacent tissues. This, I think, explains the spread of peritonitis which sometimes follows colonic resections; it is due to exploration and manipulation of the growth rather than to leakage at suture lines or other technical failure.

On completion of adequate preoperative preparation in those cases in which inoperability has

not been proved, one is called on to determine the type of surgical attack that offers the lowest mortality compatible with widespread extirpation of the growth and contagious node-bearing tissue. Several factors influence the choice of operation in the two halves of the colon. The proposition of graded operations on either side, however, is of considerable importance. Procedures in multiple stages in colonic resection were recognized many years ago as having distinct advantage, and Block, in 1892, first suggested employment of this method, as a deliberate step in eradication of a malignant neoplasm of the large bowel. It is now generally agreed that graded procedures in operations on the colon and rectum enhance markedly the final satisfactory outcome. In operations on the large bowel, the pressing necessity demanding operations in multiple stages for benign or malignant conditions, usually revolves around obstruction, acute or chronic, or concurrent disease affecting the general well-being of the patient. Combating either of these conditions, in order to permit as nearly as possible a return to normal physiologic equilibrium and to raise the margin of safety, while expanding the opportunity for radical removal of the lesion and node-bearing tissues in the immediate vicinity, if the lesion is malignant, approaches the most desirable performance.

It is apparent that in order to accomplish this one must frequently disregard the economic status of the patient, as well as the protest of both patient and physician against prolonged convalescence, and yet, eventually to consummate either cure or prolonged palliation is the aim of all surgical procedures. The faculty for judging the patient's resistance, and of apportioning formidable procedures according to his ability to withstand them, unquestionably is the product of experience, and to misjudge often means a decided increase in the rate of mortality. Although, in the majority of instances, graded procedures can be executed with nominal safety in the interval of from two to three weeks, an increase in the time allowed to elapse between stages in operations on both the right and left halves of the colon, in my experience, has proved highly satisfactory. The danger of spread of the malignant growth during the longer period of waiting is probably not as real as it seems to be. Since carcinoma of the colon, as we see it at the clinic, has given symptoms for an average of ten and a half months before operation, there can be little cause for alarm in waiting another four or five weeks after the preliminary stage of the operation, if by doing so more patients out of 100 can be submitted to resection.

In the right half of the colon, I believe that ileocolostomy between the terminal part of the ileum and the transverse colon, followed by resection of the right segment at the same time, or at a subsequent time, is the procedure of choice. Ileocolostomy can be performed satisfactorily by any one of several technics, provided it is done by end-to-end rather than by lateral anastomosis. The latter method fails adequately to divert the fecal current, and since this is the most essential feature of a graded maneuver, I believe the end-to-side union, which also more nearly approaches the natural anatomic relationship of ileum to cecum, is preferable. In performing end-to-side ileocolostomy I prefer to use a clamp which I have devised to do this aseptically, and then wait for a period of approximately four weeks or longer before doing the resection. One may, for good reason, decide to accomplish the resection at once, but this is a decision which must be made at the operating table in each case, on its own merits, and few rules can be laid down. A small growth, not associated with a perforative process and adhesions to contiguous structures, in a sufficiently robust patient may readily justify a procedure in one stage. Earlier diagnosis in carcinoma of the right half of the colon perhaps would enable one to accomplish an operation in a single stage in 25 to 30 per cent of the cases. Decompression in these one-stage procedures by enterostomy applied to the terminal part of the ileum, is to be strongly urged in every instance in order to release tension produced by pressure of gas on the suture line.

After the preliminary anastomosis is made, the second stage of the resection is readily accomplished. It consists in mobilizing the right half of the colon through division of the avascular peritoneal attachments to the lateral abdominal wall, rotation of the whole segment mesially, ligation of the vessels as they come into view, division of the bowel proximal to the anastomosis, and finally, peritonization of the remaining raw surfaces. I am accustomed to establishing drainage in these cases because of the tendency toward accumulation of exudate over the raw surface, and I have never had cause to regret this practice.

Exploration of the abdomen, before deciding on the type of procedure to be undertaken, is important, and it is customary with us to conduct this at the preliminary stage. The exploration should always be carried out in the following routine: (1) the liver; (2) the aortic nodes; (3) the nodes at the bifurcation of the iliac vessels; (4) the pelvic flow, and (5) the growth and the adjacent lymphatic structures. Extremely careful palpation of the growth will often elicit such pertinent information as: (1) existence of abscess; (2) mobility and resectability, and (3) invasion of local nodes. Lack of gentleness may readily lead to inadvertent rupture of an unsuspected abscess, secondary to a perforating malignant lesion or diverticulitis. There is no need for repetition of the exploration at the second stage of the operation, and therefore, less of the peritoneal cavity is exposed to contamination.

The problem presented in the left half of the colon, where obstruction is the most serious concern, is somewhat different from that encountered on the right side. Beyond the middle of the transverse colon, and down to the juncture of the middle and lower thirds of the sigmoid, I prefer to remove the involved segment of the colon at one stage by an obstructive type of resection in every instance in which chronic or subacute obstruction can be counteracted by preoperative tactics. If the obstruction is acute, preliminary drainage, either by blind cecostomy or by colostomy proximal to the lesion, is urgently necessary. Later resection of the growth and anastomosis can be performed in two stages. This emergency procedure, however, will be required in relatively few cases. In most instances, obstruction by the growth is mild, or has been largely relieved by preoperative preparation, and resection in one stage, but without anastomosis, is preferable. Obstructive resection is a radical procedure, which embodies the desirable features of the Mikulicz exteriorization operation, yet avoids many of its disadvantages, namely: (1) inability to remove regional lymphatic structures without sacrifice of blood supply to the parts; (2) limiting its use to highly mobile segments, unless extensive mobilization is effected and this frequently jeopardizes the blood supply, and (3) the high incidence of direct transplantation of malignant cells into the wound. Moreover, obstructive resection is attended by a considerably lower mortality, yet permits as radical extirpation as can be consummated by any surgical procedure. One can, after removal of the bowel, make sure of the blood supply to its ends by visual inspection.

The technic of obstructive resection is similar to two stages of the Mikulicz operation employed in one step, and is applicable to any portion of the colon that is mobile or mobilizable. The procedure is contraindicated in the face of obstruction. The steps of the operation are as follows: (1) incision over the growth and abdominal exploration; (2) mobilization of the growth; (3) ligation of the blood supply, and dissection of lymph nodes; (4) resection of the growth between clamps, with cautery; (5) peritonization and closure of the rent in the mesentery, and (6) closure of the abdominal wound around the two ends of the bowel held in the special clamp. The instrument employed is a three-bladed clamp which was originally devised for aseptic anastomosis. This clamp is left on the two ends of the bowel, permitting the colon to remain totally obstructed for forty-eight to seventy-two hours. At the end of this time, the proximal blade of the clamp is released, and pressure of gas opens the agglutinated end of the colon, decompressing it at once. The subsequent stages of the operation are completed exactly as in the Mikulicz procedure. As a rule, most of these wounds heal spontaneously within two months, if sufficient spur has been removed between the two approximated ends of the bowel, and portions of the mucous membrane have not been left attached to the skin.

I desire to make myself clear in regard to the Mikulicz procedure; it is not my purpose entirely to condemn it, but rather to emphasize that if used indiscriminately as a routine, it is frequently unsafe, and attended by high mortality and frequently by recurrence. I fully concur in the statement of contraindications as laid down by Sistrunk, a few years ago; namely, (1) adherent growths associated with infection of the intestinal wall and contiguous tissue; (2) large growths associated with infection; (3) growths associated with obstruction, and (4) growths in the sigmoid with short mesentery in obese patients, with thick abdominal walls. If one is guided by this list of contraindications, there will be few opportunities in which to apply the Mikulicz procedure. It is my opinion that the procedure as originally performed is most aptly applied to a small, annular, scirrhous growth, in a mobile segment of the colon, of an elderly patient, who is unable to withstand any extensive operative procedure, and in which under local or light general anesthesia, the growth can be drawn quickly into the wound without manipulation or attempt at mobilization.

Occasionally, at exploration for a lesion of the left half of the colon, one encounters a thickened and somewhat distended colon, although there had been no previous evidence of obstruction, and in spite of the fact that the patient had received adequate cleansing irrigations during the preoperative period. To resect the bowel under such circumstances would be courting disaster. Decidedly one should institute surgical decompression in such cases, either by cecostomy or by colostomy proximal to the growth, and abandon resection until the bowel has had an opportunity to return to a condition which approaches normal. The question of surgical decompressive measures in general is important. Although I do not advocate its use as a routine, preliminary to resections of the colon, I am thoroughly in accord with the principles as laid down recently by Whipple. The advantages of cecostomy as enumerated by him, are about as follows: (1) it enables adequate cleansing of the colon before resection; (2) it permits complete rest of the anastomosed segment until the period of fibroplasia is complete; (3) it increases the comfort of the patient by reducing distention and pains produced by peristalsis; (4) it obviates the temptation, and the necessity in some cases, of employing enemas in the critical period of repair, and (5) recognized as essential in cases of acute or complete obstruction of the colon and rectum in which the patients are desperately ill, it should be even more efficacious in the case in which there is no obstruction.

Rigid adherence to a standardized postoperative regimen by patients who have undergone colonic

resection is immensely to be desired. On my service, the following regimen is instituted after every operation on the large intestine, to be carried out for at least the initial forty-eight hours: (1) nothing by mouth; (2) no proctoclysis or enema; (3) hypodermoclysis, 2000 c.c. of physiologic solution of sodium chloride daily; (4) intravenous administration of a 10 per cent solution of dextrose made up in physiologic solution of sodium chloride, 1,000 to 2,000 c.c. daily, in most cases; (5) morphine liberally, in doses sufficiently large to allay pain and control active peristalsis, and (6) strict oral hygiene, aided by the chewing of gum and slices of lemon in an effort to prevent parotitis. Adequately prepared patients are surprisingly free from gas in the postoperative period, and it is my experience that much of the discomfort following abdominal operations, on both the colon and the other viscera, is the result of feeding the patient too early in convalescence. In the more formidable procedures, such as the combined abdominoperineal operation, and total colectomy, I make it a practice to give transfusions of blood almost as a routine, either the day of the operation or the next day.

Consideration of statistics of operability in operations on the colon cannot be made apart from those of mortality; the one reflects on the other. The term, "operability," is a highly controversial designation which implies conditions favorable and unfavorable to removal of malignant growths, conditions which in borderline cases must be measured and evaluated by the judgment, experience, and boldness of the surgeon. The enormous influence of the personal equation in estimating operability is attested by the wide variation in the percentages of operability of the various surgeons. The standard of operability, however, has gradually improved with refinement of surgical technic in development of greater skill by the individual surgeon. The usual standards by which operability can be determined include such modifying influences as obesity, the general condition of the patient, duration of the lesion with its attendant signs and symptoms, and various local conditions associated with the neoplasm, such as size, situation, and mobility, the relative malignancy, and the presence or absence of metastasis, both lymphatic and visceral. Naturally, hepatic metastasis precludes resection in most instances. I believe, however, that one may occasionally find justification in executing a palliative resection in the face of hepatic metastasis when this can be accomplished with relatively little danger by some simple procedure. Especially is this justifiable if there is impending obstruction which calls for colostomy. Resection in such cases, carefully selected, may be no more formidable than would be colostomy. Patients who die from carcinoma of the liver experience comparatively little pain, certainly far less discomfort than is produced by an ulcerating, penetrating, and discharging malignant lesion of the bowel.

I believe that operation should rarely be refused on the grounds of local fixation. It has been our experience that fixation results more often from inflammatory reactions than from malignant extension, and should not be regarded too seriously as an obstacle to subsequent removal, particularly if this can be accomplished in two stages. In many cases, growths which at primary exploration have been deemed inoperable, have, after side-tracking of the fecal current and constant irrigation and application of other medical measures, receded to such an extent that radical operation was feasible, and with entirely satisfactory end results. A decrease in percentage of operability will produce corresponding lowering of the hospital mortality, but in the light of comparative results with other therapeutic agents, suppression of carcinoma calls for the extension in the scope of operability. Certainly one loses little, and perhaps gains much, if a questionable growth is extirpated, even unsuccessfully.

During the last ten years, the direct mortality following operations on the colon has gradually decreased. At the Mayo Clinic, we have been particularly gratified with the results which have followed the inauguration, three years ago, of a special service for the cooperative treatment of all cases of disease of the large intestine. This has lowered the hospital mortality rate, while, at the same time, the operability has been considerably extended. The operability for 1930 and 1931 was, respectively, 57.5 and 56 per cent. During this time the mortality rate was reduced to 10.9 per cent in 1930 in a series of 712 operations for organic lesions of the colon and rectum, 68 per cent of which were carcinomatous. In 1931, the mortality rate in 719 operations was 9.1 per cent. Still, too few patients with carcinoma of the colon seek relief at an early period in its development, although one is definitely impressed that a greater number is seen at an earlier stage than was the case a few years ago.

Many Children Blinded by Dangerous Toys

Absolute prohibition of the manufacture and sale of dangerous toys such as air rifles, cap pistols, slingshots, bows and arrows, darts, toy guns, and other devices for projecting missiles, firecrackers and torpedoes is advocated by the National Society for the Prevention of Blindness in the report of a study of eye accidents in child play made public by the Society.

The Society finds that there are now in schools for the blind some 500 children who have lost their sight as a result of accidents, chiefly through the use of fireworks, air rifles, and other weapons. Each year between 750 and 1,000 children suffer accidental eye injuries in the United States, according to the report.

I. Discourse on a Visit to the Symposium

By Socrates Asklepian

—Why, Theocritus and Janus, did you trouble to discover me in these fields beyond Athens where I did come to rest?

—We would not offend, Master, but we did both make escape from the symposium of the followers of Hygeia and Chiron to seek your judgment, and in a serious matter. Two newborn sons of Athens have been mixed in the Temple of Health and neither matron doth know the which is hers. Doth seem that the emplastra slipped; and the symposium is divided in opinion, the Emplastracists defending their practice and the opposition crying loudly for the substitution of more enduring beads of color, and plates of metal, hand graven.

—I believe that I understand the problem, Theocritus. The Athenian matron doth still clamor to suckle the child of her own loins, instead of that of another's, in spite of my pupil Plato's arguments to the opposite. And since the newborn are these days given life in a common chamber of the Temple and are pulpy, they look so much alike that marks of identification are necessary.

—Exactly, Master. And we have hasted here to inquire what sort of marker you would adopt.

—It seems to me that all the conventions you have cited have slippage possibilities. Believe you that Chiron's followers would accept brands, marks burnt into the flesh of mother and child as nomads, I know, mark their kine with the seal of the house?

—You make sport, Master, of a subject which has made for bitterness these three days past in the symposium.

—I was not for offending you, Theocritus; though I must protest that you seem to have come to me not for discourse on a principle which would be defensible in logic and practical in making for identification but rather for a critique of the relative merits of emplastra, or glass, or metal markers.

—True, Master, for the schools of Athens and Sparta do break over these matters.

—We must hear the arguments slowly. Suppose you, Janus, speak for the Emplastracists.

—It is easily done, Master. An emplastrum is known to all the schools of Asklepios and Chiron; it may be found in any tool chest or nurse-virgin's kit and some relative of the expectant matron is sure to have an indelible stylet in his tunic. The situation is, therefore, as it were, always prepared for the new Greek's coming, and, more important, for the new Greek's going from his matron to the infantorium.

—Janus has spoken well, Theocritus. Can you counter his logic?

—That I can, Master. The nurse-virgins do these days anoint with oil rather than lave the newborn. Emplastra do commingle with oil and roll below the palm and come off. And an emplastrum, Master, once it has lost its stick can no more be stickéd. I opine that beads are better, strung on fish line, in neat design. The expectant matron may fill the time of her expectancy purchasing fish line and stringing the beads; and knowing the design she has created, always thereafter, will she be able to recognize her beads no matter to what child they may be attached.

—I must protest, Theocritus, that your otherwise strong argument weakens in its final sequences. Is the matron's interest in getting back her bead work not likely to surmount her interest in the major problem, which is to get back her infant?—What say you, Janus?

—The failure of the emplastrum to hold to its emplastral nature does profoundly affect me. The weight of argument seems to be with nature's less changeable forms. I bow therefore to Theocritus' reasoning but not to his forms. I urge in consequence that those simplest of nature's elements that we do call the metals replace his fragile beads and fish lines. I suggest the old army button of the new-found aluminium and graven in duplicate for mother and child with names of parents of child, whether wedded or not, anticipated anointal name of infant, its legal name, its address, the calendar year, the name of the calendar used and the Temple's serial number; and wire is suggested to replace the fish line.

—Your thoughts are certainly to be commended, Janus. I do myself discern the advantage of metals in case of fire in the Temple of Health. Buttons and serial numbers could scarce be harmed by the heat of Herakles. My only hesitancy regarding these tags in double, lies in a not always determinable mathematical factor. What if there should be twins? Such an event would work serious detriment to the serial numbers and by indirection to that new science, statistics.—Do you return now to the symposium?

—That we do, Master. And may we say that we have had lesson with you?

—That you may.

—And may we say further that, in principle, you are for the old army identification tag?

—That you may do also.

—And shall we add that you do indorse as progressive these new temples of maternity which do so immediately and effectively separate mother from child that neither can find the other save by the virtue of the old army button?

—That you may not. You may say that I find a larger quantum of virtue in beads than in emplastra, and more in metals than in beads; but most virtue do I find in leaving a mother and child asleep upon their common couch.

Committee Appointments; Preliminary Annual Meeting Plans; Policy, Ethical and Governmental Questions, Considered at July Council Meeting

The Council of the Ohio State Medical Association met in the headquarters office, Columbus, at 1:00 P. M., on Sunday, July 10, 1932.

The Officers and Councilors present were: President, Dr. Platter; Ex-President, Dr. Houser; Treasurer, Dr. Beer; Councilors, Drs. Caldwell, Huston, Klotz, Hein, Davidson, Shanley, Brush, Seiler, Goodman; Dr. Alcorn, chairman of the Policy Committee; Dr. Southard, State Director of Health; Executive Secretary Martin and Assistant Executive Secretary Nelson.

The minutes of the Council meetings held during the recent annual meeting of the State Association in Dayton, May 2, 3 and 4 (published on pages 457 to 460, inclusive, of the June, 1932, issue of *The Journal)*, were read, and on *motion* by Dr. Klotz, seconded by Dr. Huston and *carried*, were *approved.*

Dr. Platter, the President, announced the unavoidable absence from today's Council meeting, of Dr. Cummer, detained at home on account of illness; and Dr. Paryzek, who had come to Columbus for the meeting, but who was called home on account of serious illness in his family.

COMMITTEE APPOINTMENTS

Dr. Platter, the President, announced the appointment of the following committees (in addition to the standing comittees already appointed and confirmed by the House of Delegates at the recent annual meeting):

Council Committee on Auditing and Appropriations

S. J. Goodman, Chairman, Columbus
John A. Caldwell, Cincinnati
I. P. Seiler, Piketon.

Council Committee on Program

C. L. Cummer, Chairman, Cleveland
B. J. Hein, Toledo
E. R. Brush, Zanesville.

Special Members Added to Policy Committee

(Last three past-presidents)
D. C. Houser, Urbana
C. W. Waggoner, Toledo
Albert H. Freiberg, Cincinnati.

On separate *motions*, duly seconded and *carried*, the Council confirmed the appointments of each of the foregoing committees.

Special Committee on Military and Veterans' Affairs

The President called attention to the resolution adopted by the House of Delegates at the annual meeting, authorizing the appointment of a committee to confer and cooperate with officials of the American Legion, with the hospital and rehabilitation committees of that organization, in regard to veterans' benefits, hospitalization, medical service and similar matters.

Pursuant to the House of Delegates action, Dr. Platter announced that by and with the consent of the Council (which was granted), he would combine the functions of the special committee thus authorized, with the regular Military Committee, and announced the committee personnel as follows:

C. W. Stone, Chairman, Cleveland
Fred K. Kislig, Dayton
A. E. Brant, Youngstown.

Special Committee on Preventive Medicine and Periodic Health Examinations

The President announced that with the consent of the Council (which was granted) the title of the special committee heretofore known as the Committee on Periodic Health Examinations, would be changed to the Committee on Preventive Medicine and Periodic Health Examinations; the committee personnel to be re-appointed as follows:

V. C. Rowland, Chairman, Cleveland
Jonathan Forman, Columbus
Beatrice T. Hagen, Zanesville
R. R. Hendershott, Tiffin
C. I. Stephen, Ansonia.

On separate *motions*, duly seconded and *carried*, the Council confirmed the appointments of the foregoing special committees.

ANNUAL MEETING MATTERS

Dr. Goodman, chairman of the Auditing and Appropriations Committee, submitted to the Council a final financial statement of the annual meeting held in Dayton, May 3 and 4, supplementing the preliminary statement issued on June 1, and showing a balance, accruing to the State Association from the annual meeting, of $588.80.

Several Councilors reported on their observations at the recent annual meeting, and made suggestions for future improvements. Dr. Goodman read a report on the Dayton meeting, containing compliments to the local committees, and suggestions for avoiding certain difficulties in the future. The consensus of opinion of those present was that the Dayton meeting was quite successful.

New Type of Set-up and Schedule for 1933 Annual Meeting

On behalf of Dr. Cummer, chairman of the Council Program Committee, Dr. Platter re-

ported on a conference of the Program Committee held on the morning of this day, and on previous conferences with Dr. Cummer, based on the provision of the newly revised Chapter III of the By-Laws of the State Association, permitting greater flexibility in the schedule and arrangement of scientific sessions during the annual meeting. Dr. Cummer's report recommended that the 1933 annual meeting be confined to two days; that the opening general session and the House of Delegates convene at 10:30 A. M. on the first day; that the organization luncheon be held at 12:00 o'clock sharp at noon; that the afternoon of the first day be devoted to six scientific sections, and that they be the only section meetings scheduled; that Tuesday evening the annual addresses of the retiring and incoming presidents be presented, and if a banquet precedes those addresses, the entire responsibility for it be assumed by the local medical society; that the morning of the second day of the annual meeting be devoted to a general session of eight addresses to be of the greatest possible appeal and benefit to the physicians in general practice, and representing various fields of medicine, that each of those addresses be confined to twenty minutes and that there be no general discussion; that on the final afternoon, starting promptly at 1:00 o'clock, there be another general session of perhaps three speakers, probably from Western Reserve University, on subjects chosen by the Council Program Committee of general interest to the profession; that the final session of the House of Delegates and the concluding session of the annual meeting, be held at 3:30 P. M. on the second day.

Members of Council submitted suggestions for avoiding repetition and duplication of essayists and discussants. The Council especially approved the recommendations of the Council Program Committee for definite limitation of time of essayists and discussants, both in the section meetings and the general sessions, with an exact time schedule in the program for each session, to which adherence would be demanded.

Time and Place for 1933 Meeting

The President reported on a conference held in Akron on Sunday, June 26, for the purpose of surveying the facilities in that city for the annual meeting next year. He reported in detail on the facilities at the Mayflower Hotel and the auditoriums which would be available nearby. Dr. Davidson supplemented Dr. Platter's report on this matter.

Upon *motion* by Dr. Houser, seconded by Dr. Seiler and *carried*, Akron was selected for the 1933 annual meeting, based on the authorization granted the Council by the House of Delegates at the last annual meeting.

Information was submitted for the consideration of the Council on other medical meetings, especially national special societies, which would convene the first week in May, 1933. An effort was made to avoid conflicts in dates as much as possible.

Upon *motion* by Dr. Seiler, seconded by Dr. Klotz and *carried*, the Council officially set the dates for the next annual meeting as Tuesday and Wednesday, May 9 and 10, 1933.

Upon selection of the time and place for the next annual meeting, the President announced, as follows, the appointment of the

Council Committee on Arrangements

H. S. Davidson, Chairman, Akron
E. M. Huston, Dayton
E. B. Shanley, New Philadelphia.

Upon *motion*, seconded and *carried*, the Council confirmed this committee appointment.

Dr. Davidson as chairman of the Council Committee on Arrangements, recommended the selection of Dr. E. A. Weeks of Akron as the general chairman of the local committees on arrangements for the next annual meeting of the State Association, as contemplated under Section 6, Chapter VIII of the By-Laws of the State Association.

On *motion* by Dr. Davidson, seconded by Dr. Caldwell and *carried*, the Council made this appointment.

ETHICAL QUESTIONS

At the request of a member, the Council considered proposed billboard advertising of a private sanatorium. A written but unofficial opinion from the Chairman of the Judicial Council of the American Medical Association on this matter was read.

On *motion* by Dr. Goodman, seconded by Dr. Hein and *carried*, the Secretary was instructed to notify the members who submitted the question that such proposed type of advertising is objectionable.

The question was submitted for consideration on an advertisement of a clinic operated by a physician jointly with others who are not physicians.

Upon *motion* by Dr. Brush, seconded by Dr. Caldwell and *carried*, this matter was referred back to the county society in the county in which such clinic is located, and attention called to the interpretation by the Council of a similar question, published on page 651 of the August, 1931, issue of *The Journal*.

SUGGESTED ENLARGEMENT OF THE COUNCIL

Dr. Houser discussed at some length questions which have arisen in his many visits to the county medical societies during his term as president last year. He emphasized the necessity by the Councilors for stimulating organization interest in the counties in their districts. He referred to previous suggestions which he had made

concerning the possibility of redistricting the State, with a possible idea of increasing the number of Councilors. He discussed the importance of the county unit and the idea of joint meetings between adjoining county medical societies. He also discussed the possible effect of non-resident membership. He also called attention to a suggestion that had been made that the Council might be increased by extending the term of service on the Council of the retiring presidents.

Among other Councilors who discussed the various organization problems raised by Dr. Houser, were: Dr. Davidson, Dr. Huston, Dr. Goodman, Dr. Hein, Dr. Caldwell and Dr. Brush.

Upon *motion* by Dr. Huston, seconded by Dr. Caldwell and *carried*, the President was requested to appoint a committee from the Council to consider the various suggestions for changes in the Council set-up, increase in numbers, possibility of redistricting, and similar matters, and to report to the Council at a later meeting.

Pursuant to the adoption of that motion, the President announced the appointment of such special committee as follows:

D. C. Houser, Urbana
C. L. Cummer, Cleveland
O. P. Klotz, Findlay.

COMMUNICATION FROM STATE NURSES' ASSOCIATION

There was presented to the Council an official communication from the Ohio State Nurses' Association, signed by Elizabeth P. August, General Secretary, expressing appreciation to the Council of the Ohio State Medical Association for support and cooperation.

The Council officially received the communication, expressed gratitude for its sentiments and pledged continued interest and cordial cooperation to that association.

LEGISLATIVE AND GOVERNMENTAL

Dr. Alcorn, chairman of the Policy Committee, reviewed recent developments of a governmental nature, affecting public health and medical practice. He referred to the series of recent bulletins from his committee, preliminary to the next legislative session. He summarized information submitted by legislative committeemen. He analyzed the problems and prospects for the general election next November. He emphasized what the Councilors could do to secure greater response and activity on the part of the legislative committeemen and officers of the county societies in their respective districts. He requested suggestions from members of Council on the legislative handbook.

On *motion* by Dr. Seiler, seconded by Dr. Klotz and *carried*, the Council left with the Policy Committee, determination of whether or not a new legislative handbook should be issued, or whether a supplement should be used with the latest handbook.

On *motion* by Dr. Davidson, seconded by Dr. Huston and *carried*, the Secretary was requested to transmit to each member of Council, a list of the legislative committeemen in their respective districts from which no replies have been received, with information in response to the request which accompanied the last legislative bulletin. That motion also contemplated the draft of a suggested letter to the legislative committeemen from the Councilors.

There was distributed for the information of the Council, recent charts and tabulations issued by the Ohio Inter-Organization Tax Association, analyzing distribution of taxes by counties, and public debts, especially in the field of education, welfare and health; these being charts 6, 7 and 8 in the series. Members of Council discussed the importance of these questions and the possibility of legislation pertaining to them.

Attention was also called to the pending constitutional amendment "for economy and efficiency in local government". This was discussed by several members of the Council, especially as applying to the public functions in counties in the field of health and welfare. Attention was called to the question to be voted on at the coming general election as to whether or not a constitutional convention should be called to amend and revise the present Constitution and By-Laws of the State of Ohio. Several members of Council discussed the trend of the times in governmental functions, including the propaganda support for a social insurance program.

An analysis was made of the recently enacted emergency relief laws, supplementing the poor laws of the State. Announcement was made that an opinion of the Attorney General, interpreting some of these phases as applied to medical and hospital relief, will be published in the next issue of *The Journal*.

WORKMEN'S COMPENSATION

A report was submitted on the questions raised at the last Council meeting by some of the members specializing in roentgenology, relative to the inclusion of *X*-ray services in the annual contracts between the Industrial Commission and hospitals for the care of workmen's compensation cases.

Following a detailed discussion of this question, on *motion* by Dr. Brush, seconded by Dr. Seiler and *carried*, it was suggested to the Medical Economics Committee as the sense of Council that the Industrial Commission should be requested to eliminate "*X*-ray service" from the summary of services included in the patient-day cost in the official contract form between the Commission and hospitals; unless "*X*-ray service" is requested by

the hospital making the contract, to be included in the per diem cost contract rate.

Numerous other problems in connection with workmen's compensation were discussed by several members of the Council, including an official communication to the Ohio Hospital Association; question of a request for increase in fees for gas anesthesia; question of payment for *X*-ray following reductions of fractures; considerable recent correspondence indicating a concerted movement for changes in the compensable occupational disease list; reference to previous policy on this and other questions as set forth in reports of the Medical Economics Committee; increase in the amount of medical and hospital fees for workmen's compensation; proposed new regulations by the Commission in relation to physicians; various difficult problems of administration and the importance of mutual understanding and cooperation between physicians and the Industrial Commission.

MEMBERSHIP AND FINANCIAL QUESTIONS

A report on membership in the State Association to date for 1932 showed a total of 5,179 as compared with 5,335 on the same date last year, and as compared with a total of 5,589 at the end of 1931.

Dr. Goodman, chairman of the Auditing and Appropriations Committee, reported on the status of the budget, prospective income, advertising revenue, printing costs of *The Journal*, a comparative financial status with other state-wide organizations and similar matters. He announced that in spite of the slight but anticipated decrease in membership and the anticipated decrease in advertising from *The Journal*, the Association would not only be able to operate within the budget authorized by the Council for the calendar year, but that there might even be a balance rather than a deficit on income over expenditures for the calendar year..

MISCELLANEOUS

A brief report was submitted on the participation of Ohio physicians in the recent A. M. A. meeting in New Orleans, and reference made to the article on this subject on pages 472 and 473 of the June issue of *The Journal*.

A communication from Dr. J. P. DeWitt, Canton, which was accompanied by the manuscript of a paper by Dr. M. L. Harris, Chicago, on "County Medical Centers", was read to the Council. Reference was made to a summary of comments on some of Dr. Harris' ideas for clinics operated by county medical societies, published on pages 697 to 701, inclusive, of the September, 1929, issue of *The Journal*.

On *motion* by Dr. Huston, seconded by Dr. Seiler and *carried*, this correspondence and manuscript were referred to the Policy Committee for consideration and action.

Announcement was made of considerable correspondence and other developments in relation to the possibility of an injunction suit in relation to the legal service features of the medical defense plan. The Council requested the Medical Defense Committee and the state headquarters office to keep in touch with developments and to participate in such conferences as are contemplated.

Dr. Shanley discussed the possibility of including in *The Journal* a department or a forum for questions and answers on medical problems. Upon *motion* by Dr. Klotz, seconded by Dr. Shanley and *carried*, the question of such a department was referred to the Publication Committee for consideration.

On *motion*, the Council *adjourned* to meet sometime early in October on a date to be set by the President.

S. J. GOODMAN,
Secretary of Council.

Ways to Solve Nurses' Dilemma Suggested

Aid in stemming the increasing stream of nursing school graduates is asked of hospital trustees throughout the United States by organized nursing in an open letter recently posted and bearing the signatures of the presidents of the American Nurses' Association, the National League of Nursing Education, the National Organization for Public Health Nursing and of the chairman of the committee on distribution of nursing service of the A. N. A.

The best thought of all groups concerned will be needed to work out the adjustments in nursing that the next few years will require, the letter points out. But certain steps can be taken now, it contends, to help tide the nurses over the present crisis without adding to the financial embarrassment of the hospitals. These steps are as follows:

1. Better selection of students, thus cutting down the cost of carrying large numbers of probationers for several months only to eliminate from 25 to 50 per cent of them.

2. Employment of ward helpers, maids, orderlies, attendants and secretaries to do a large amount of routine work done by students.

3. Strengthening of hospital organization by the employment of graduate nurses who are available at relatively low salaries, thus giving the doctors nursing service uninterrupted by class attendance and the patients the care of more experienced nurses.

4. Tuition fees for students in schools offering a sound and well organized teaching program; also use of facilities of nearby educational institutions to save part of the cost.

5. Abolishment of allowances and use of the funds for teaching the students.

Medical and Hospital Care to Indigents Under the Newly Revised Poor Relief Laws, Interpreted by the Attorney General

An opinion concerning the furnishing of medical and hospital care to indigents under the poor relief laws was given recently by Attorney General Gilbert Bettman, in answer to a series of inquiries made by the State Bureau of Inspection and Supervision of Public Offices.

Attorney General Bettman's opinion was in answer to the following questions:

1. May a village contract with a city in which is located a general hospital, for the hospitalization of indigent persons who reside in the village, and may a village expend public funds for hospital care of indigent residents?
2. In the preparation of the budget under the provisions of Senate Bill 4, passed by the 89th General Assembly at its special session held March 29, 1932, may the county commissioners consider the necessities of a particular village in allotting to a township its portion for poor relief where such village has contracted for hospitalization of indigent residents of the village?
3. When the corporate limits of a village become identical with those of a township, may the village expend funds for poor relief as defined in Sections 3476 to 3494, General Code?
4. In the preparation of the budget under the provisions of Senate Bill 4, passed by the 89th General Assembly at its special session held March 29, 1932, may the county commissioners allot funds to a village for poor relief purposes, when the corporate limits of such village are identical with those of the township?
5. When the corporate limits of a village are identical with those of a township, is the village entitled to allocate gasoline tax and automobile license funds for poor relief purposes, with the approval of the State Relief Commission, under the terms of Senate Bill 3, passed March 31, 1932?

In answer to the first inquiry, relative to the expenditure of funds by a village for hospital care of its indigents and whether a village may contract with a city for such hospitalization, Mr. Bettman made the following explanation of the statutes:

"Section 3480, General Code, reads as follows:

"'When a person in a township or municipal corporation requires public relief, or the services of a physician or surgeon, complaint thereof shall be forthwith made by a person having knowledge of the fact to the township trustees, or proper municipal officer. If medical services are required, and no physician or surgeon is regularly employed by contract to furnish medical attendance to such poor, the physician called or attending shall immediately notify such trustees or officer, in writing, that he is attending such person, and thereupon the township or municipal corporation shall be liable for relief and services thereafter rendered such person, in such amount as such trustees or proper officers determine to be just and reasonable. If such notice be not given within three days after such relief is afforded or services begin, the township or municipal corporation shall be liable only for relief or services rendered after notice has been given. Such trustee or officer, at any time may order the discontinuance of such services, and shall not be liable for services or relief thereafter rendered'.

"Section 3490, General Code, provides that the trustee of a township or proper officers of a municipal corporation may contract with physicians to furnish medical care and medicines necessary for the persons who come under their charge under the poor laws.

"Section 3480-1, General Code, provides a manner of furnishing medical services and hospital care in cases other than contagious to persons having a legal settlement in a municipality or township other than that in which the service is rendered, and provides the method of charging back payment for such services to the municipality or township in which such persons have a legal settlement.

"The duty of furnishing the public support and relief provided for in section 3476, General Code, is placed upon townships, cities and counties. As this section mentions cities and not municipal corporations, villages are excluded, and this office has repeatedly held that it is the duty of the township in which a village is located, and not of such village, to afford the poor relief provided for by this section to residents of such village. On the other hand, the statutes dealing with medical relief use the terms 'municipal corporations' and 'municipalities'. These terms include both cities and villages. Villages also are given the right to construct and maintain hospitals. Sections 3646 and 4356, General Code.

"Section 4021, General Code, provides for the levy of a tax by a municipality and payment thereof to a private corporation or association which maintains and furnishes a free public hospital for the benefit of the inhabitants of the municipality or not free except to such inhabitants as in the opinion of the hospital trustees are unable to pay, such payment to be as and for compensation for the use and maintenance of such hospital. Section 3621, General Code, gives municipalities the power to provide for the rent and compensation for the use of any existing free public hospital established and managed by a private corporation or association organized for that purpose.

"In view of these statutory provisions, *I am of the opinion that a village may expend public funds for hospital care of its indigent inhabitants who need such service. Charges for services afforded by a hospital are as much a proper item of medical relief as any other charges. I find no express statutory authority for a village to contract with a city for the hospitalization of its indigent inhabitants, but as villages may afford*

medical relief, I am of the view that where a village has no hospital facilities it may make such arrangements with a city having a hospital in the absence of any statutory inhibition."

The second inquiry, relative to whether a village may be considered by the county commissioners in allotting poor relief funds, was answered by the Attorney General as follows:

"Section 9 of Amended Senate Bill No. 4, passed March 31, 1932, at the special session of the 89th General Assembly, reads in part as follows:

" 'No disbursement of any part of the emergency relief fund shall be made by the county commissioners or the council or other legislative body of any city of any county until the budget of such county or city for relief expenditures has been approved by the state relief commission. At any time after such approval and in accordance therewith and prior to the first day of March, 1933, the county commissioners of any county shall, from time to time, distribute such portion of said fund to any or all of the cities (whether charter cities or otherwise) and townships of such county, according to their relative needs for poor relief as determined by such county and as set out in such approved budget; such moneys so distributed to any city or township shall be expended for poor relief in such city or township including the renting of land and the purchase of seeds for gardening for the unemployed, and for no other purpose'.

"There is no provision in this act for the distribution of any part of the emergency relief fund to villages. In preparing their budget for relief expenditures, the county commissioners may take into consideration the necessities of a village in allotting to a township in which such village is located its portion of such fund, in so far as those necessities are to be taken care of by such township itself; that is, such relief that the township expects to afford to inhabitants of such village at the expense of such township may properly be considered by the county commissioners. However, I know of no authority by which a township can turn over any of the poor relief money received by it to a village to be expended by such village for medical relief.

"*I am of the view, therefore, that the county commissioners in making an allotment of such funds to a township can not consider the amount of money that will be expended by a village within such township for hospitalization of the sick poor of such village.*"

Mr. Bettman, in answer to Question No. 3, concerning the expenditure of poor relief funds by a village and township having identical corporate limits, declared:

"Section 3512, General Code, reads as follows:

" 'When the corporate limits of a city or village become identical with those of a township, all township offices shall be abolished, and the duties thereof shall thereafter be performed by the corresponding officers of the city or village, except that justices of the peace and constables shall continue the exercise of their functions under municipal ordinances providing offices, regulating the disposition of their fees, their compensation, clerks and other officers and employes. Such justices and constables shall be elected at municipal elections. All property, moneys, credits, books, records and documents of such township shall be delivered to the council of such city or village. All rights, interests or claims in favor of or against the township may be enforced by or against the corporation'.

"*When the corporate limits of a village become identical with those of a township, there are no longer township trustees to administer poor relief, and under section 3512, those duties may be performed by the corresponding officers of the village which would be the village council, and in such case the village may expend funds for poor relief.* Reports of the Attorney General, 1911-12, Vol. I, page 250. Opinions of the Attorney General for 1917, Vol. I, page 138; for 1928, Vol. I, page 240."

Questions No. 4 and 5 were answered as follows:

"Section 2 of Amended Senate Bill No. 3, passed at the special session of the 89th General Assembly March 31, 1932, reads as follows:

" 'At any time prior to the first day of March, 1933, the county commissioners of any county may, upon approval of the state relief commission, transfer to cities or townships in such county, all or any part of the proceeds of the gasoline and motor vehicle license taxes hereafter collected and allocated under existing laws to the county, such funds to be used for poor relief in the subdivision to which they are allocated and for no other purpose'.

"*Inasmuch as a village, whose boundaries have become identical with those of a township, takes the place of such township and has all the rights and duties with respect to administering poor relief as a township does, I am of the opinion that subject to the approval of the state relief commission the county commissioners may allot emergency relief funds to such village in preparing their budget for poor relief under the provisions of Amended Senate Bill No. 4, and may transfer to such village a part of the gasoline and motor vehicle license taxes allocated to such county for poor relief purposes under the provisions of Amended Senate Bill No. 3.*"

At the annual reunion of the Alumni Association of the College of Medicine, University of Cincinnati, held the week-end of June 10 at Cincinnati, the following officers were elected: President, Dr. Alfred Friedlander; vice president, Dr. William Doughty; secretary-treasurer, Dr. Stanley Dorst; representatives to the general Alumni Council, Dr. Carl A. Wilzbach and Dr. F. W. Heinold.

The annual banquet at the Netherland Plaza was presided over by Dr. Dudley Palmer, retiring president of the Association. The principal address was made by Rabbi James G. Heller, Cincinnati. Tributes were paid to Dr. E. W. Mitchell, Dr. B. F. Lyle, Dr. H. Price and Dr. J. Sexton representing the Class of 1882.

Two Hundred and Eighty New Physicians Licensed in Ohio and Other Business Transacted by State Medical Board in July

Two hundred and eighty licenses to practice medicine and surgery in Ohio were granted by the State Medical Board at its regular mid-summer meeting held in Columbus, July 11 and 12.

In addition to passing on applicants who took the June examinations given by the Board and on the applications of those seeking to practice in Ohio through reciprocity, the Board held several hearings and transacted other business.

Miss Caroline McKee submitted her resignation as chief examiner of the Bureau of Nurse Registration. The Board accepted the resignation of Miss McKee with regret and officially commended her for her efficient and untiring service as head of the bureau for the past 10 years. The resignation will become effective August 15. Miss McKee will retain her membership on the nurse examining committee but because of ill health asked to be relieved of the duties of chief examiner.

The Board appointed Miss Clara F. Brouse, Akron, to succeed Miss McKee as chief examiner. It also appointed Miss Louise Schroeder, Dayton, a member of the examining committee to succeed herself.

W. W. Custis, D.O., Dayton, was appointed a member of the osteopathic examining committee, succeeding Thomas Ashton, D.O., Lancaster.

Following an extensive hearing, the Board suspended the certificate of Dr. J. M. Gorslene, Cleveland, for six months on charges of grossly unprofessional and dishonest conduct in connection with alleged claims made by Dr. Gorslene that he could cure cancer, mental diseases and senility through the injection of a "mysterious" gas.

The certificate of Paul H. Strand, Youngstown chiropractor, was suspended for three months on charges of grossly unprofessional and dishonest conduct in connection with extravagant advertising.

One physician and one limited practitioner were called before the Board and reprimanded for alleged irregular practice.

Two hundred and thirty-one of those granted medical and surgical licenses had taken the examinations given by the Board in June and 49 were licensed on reciprocity.

Seventy-four of the successful applications were graduates of the College of Medicine, Ohio State University; 60 graduates of the College of Medicine, University of Cincinnati, and 56 graduates of the School of Medicine, Western Reserve University.

The average grades of graduates from the three Ohio medical schools were: Ohio State University, 83.6; Western Reserve, 83.4; University of Cincinnati, 82.4.

The ten highest grades made in the examinations were made by graduates of the three Ohio schools, as follows:

First, D. M. Palmer, Scio, Ohio State University, 90.7; second, Samuel Kamellin, Cleveland, Ohio State University, 88.2; third, H. H. Luechtag, Cleveland, Ohio State University, 87.9; fourth, J. W. Long, Columbus, Ohio State University and Carl Stein, Cleveland, Ohio State University, each 87.8; fifth, H. B. Lacey, Columbus, Ohio State University, 87.6; sixth, H. M. Salzer, Cincinnati, University of Cincinnati, 87.4; seventh, H. F. Mills, Cleveland, Ohio State University, 87; eighth, Harold Rand, Cleveland, Western Reserve University, 86.9, and ninth, T. F. Lewis, Jr., Dayton, Ohio State University, 86.8.

Certificates to practice in Ohio were granted to 16 osteopaths, 2 mechano-therapists, 2 cosmetic-therapists, 20 masseurs and 47 chiropodists.

The Board voted to hold its next meeting on Tuesday, October 4.

THE NEW PHYSICIANS LICENSED

Those granted medical and surgical licenses, together with their school of graduation and place of intended residence, follow:

Ohio State University—John R. Alley, Chillicothe; Temple A. Baldi, Cleveland; Lester D. Besecker, Laura; Byron B. Blank, Waynesfield; George P. Bohlender, Dayton; Joseph J. Brumbaugh, Canton; Howard R. Campbell, Dayton; James H. Carson, Martins Ferry; Stephen P. Churchill, Lima; Chester O. Cramer, Hilliard; David M. Creamer, Bellaire; Theodore Cutright, Lyndon; Stanford S. Daw, Wellsville; Charles J. Dinardo, Cleveland; Rollin R. Durant, Columbus; Robert E. Edler, Westerville; Richard A. Firmin, Findlay; Harold J. Friedman, Cleveland; Edgar A. Fry, Columbus; William R. Gibson, Columbus; Jack Gilford, Cleveland; Maurice S. Goldberg, Cleveland; David M. Gordon, Columbus; Grant O. Graves, Columbus; John B. Gravis, Jr., Columbus; Robert J. Hansel, Columbus; Robert W. Helms, Dayton; Lawrence M. Ihle, Cincinnati; Joseph P. Ingmire, Union Furnace; Oscar W. Jepsen, Columbus; Samuel Kamellin, Cleveland; Ross M. Knoble, Sandusky; Conrad A. Kuehn, Toledo.

Henry B. Lacey, Columbus; Orville L. Layman, Dayton; Norris E. Lenahan, Columbus; Harry H. Leuchtag, Cleveland; Joseph J. Levin, Cleveland; Milton Levine, New Boston; Tom F. Lewis, Jr., Dayton; Samuel Lobe, Cleveland; James W. Long, Columbus; William F. Lyons, Columbus; Thomas N. Manos, Columbus; Chester R. Markwood, Columbus; George T. Mathews, Columbus; John B. McLaughlin, Columbus; Umbert A. Melaragno, Cleveland; Orval J. Miller, Defiance; Harold F. Mills, Cleveland; Mervin H. Mitchell, Plain City; Dwight M. Palmer, Scio; Crawford F. Pope, Co-

lumbus; Avery D. Powell, North Baltimore; Don R. Printz, Urbana; Morris S. Rosenblum, Youngstown; Howard H. Schwindt, Dover; Abe O. Shapiro, Cleveland; Clare W. Smith, Columbus; Frank A. Smith, Painesville; Franklin M. Smith, Columbus; Carl Stein, Cleveland; William V. Stephendon, Toledo; Frank H. Sweeney, Galion; Harold O. Tagett, Columbus; Bernard J. Terrell, Cleveland; Myron W. Thomas, Cleveland; Roy H. Thompson, Cleveland; John A. Topinka, Columbus; Walter J. Tymochko, Youngstown; Thomas P. Wangler, Groveport; Harold W. Ward, Columbus; Jerome I. Wertheimer, Cleveland; Walter E. Yingling, Lima.

University of Cincinnati—Earl W. Bailey, Cincinnati; Calvin L. Baker, Cincinnati; Henry C. Beekley, Cincinnati; Joseph J. Bell, Cincinnati; Richard D. Bryant, Cincinnati; William R. Chambers, Cincinnati; Paul T. Chapman, Cincinnati; John W. Cronin, Elyria; Joseph G. Crotty, Cincinnati; Leonard M. Dub, Cincinnati; Marshall B. Dunham, Dayton; Philip H. Elliott, Cincinnati; Otto K. Engelke, Cincinnati; Joseph Filger, Cincinnati; Thomas G. Folson, Cincinnati; Albert H. Gellenbeck, Jr., Cincinnati; Jack S. George, Oxford; Edward O. Guerrant, Cincinnati; Carl F. Hammerstrom, Cincinnati; Gaston B. Hannah, Cincinnati; Albert G. Hattendorf, Cincinnati; Hyman Helfman, Hamilton; Raymond L. Hilsinger, Cincinnati; Abraham Hoodin, Cincinnati; Charles L. Howard, Cincinnati; James G. Inman, Cincinnati; Glover T. Keen, Cincinnati; Herbert W. Kendell, Covington; Roy L. Kile, Cincinnati; John J. Kobes, Cincinnati; Nathan J. Kursban, Cincinnati; Glenn S. Lamkin, Cincinnati; David L. Lerner, Cincinnati; Karl M. Lippert, Cincinnati; Richard R. Marnell, Cincinnati; Esther C. Marting, Ironton; Harvey G. McCandless, Cincinnati; Edward J. McGrath, Cincinnati; Ralph H. Miller, Cincinnati; Carl Minning, Cincinnati; Charles H. Moore, Cincinnati; Donald R. Nelson, Massillon; Ralph F. Niehaus, Cincinnati; Jean A. Nock, Middletown; Ewald H. Pawsat, Cincinnati; Louis N. Podesta, Cincinnati; Louis Reik, Cincinnati; Ernest E. Rhoads, Cincinnati; Nelson W. Ryan, Cincinnati; Harry M. Salzer, Cincinnati; Irvin R. Schaen, Cincinnati; Julius Schreiber, Cincinnati; L. Null Schroder, Lima; Arthur F. Schultz, Jr., Cincinnati; Emil A. Steiner, Cleveland; Roselyn Touff, Cincinnati; Maurice H. Weinstein, Cincinnati; Stanley W. Whitehouse, Cincinnati; Carl J. Wolf, Pomeroy; Makoto Yamaguchi, Cincinnati.

Western Reserve University—John R. Andrews, Cleveland; William W. Bartholomew, Cleveland; Robert E. Bowman, Cleveland; Patsie F. Briola, Cleveland; Antonio S. Broglio, Cleveland; Wayne E. Brown, Sandusky; Wendell T. Bucher, Cuyahoga Falls; Orange V. Calhoun, Cleveland; Glenn E. Chambers, Twinsburg; Theodore A. Coffin, Cleveland; George T. Crout, Cleveland; Stanley N. P. DeVille, Cleveland; George L. Evans, Cleveland; Curtis F. Garvin, Cleveland; Joseph M. Gledhill, Warren; Harold K. Goler, Cleveland; Joe I. Goodman, Cleveland; William A. Gorman, Cleveland; Arch H. Gould, Cleveland; Theodore A. Gross, Cleveland; Robert C. Hahn, Elyria; Rita G. Hain, Cleveland; William R. Hallaran, Cleveland; James M. Hindley, Monroeville; Laura M. Hobbs, Painesville; Robert H. Hoecker, Cleveland; William J. Horger, East Liverpool; Elizabeth S. Hutchison, Cleveland.

Harold J. Jeghers, Cleveland; Edwin A. Jirouch, Cleveland; Arthur R. Keirn, Akron; John E. Longnecker, Jr., Poland; Reuben R. Maier, Cleveland; Robert H. McCommon, Shadyside; William G. McLaughry, Cleveland; Paul A. Mielcarek, Cleveland; George D. Morse, Coshocton; Paul E. Pifer, Cleveland; Harold Rand, Cleveland; Norman Reider, Cleveland; Phillip M. Reilly, Cleveland; Donald Y. Shaffer, Cleveland; Lester Shupe, Cleveland; Karl J. Simon, Cleveland; Taylor Smith, Cleveland; Lloyd M. Snively, West Lebanon; Russell D. Steele, Cleveland; Howard Stephens, Cleveland; Sidney R. Stone, Cleveland; Reuben Straus, Cleveland; Daniel F. Toth, Cleveland; Bert A. Treister, Cleveland; John W. Viktoryn, Cleveland; Clarice E. Whitacre, Lodi; Guy H. Williams, Jr., Cleveland; Louis S. Zwick, Cleveland.

Other Schools—Gaylord D. Fridline, Ashland, Boston University; Joseph M. Lebowich, Cleveland, Boston University; George P. Wyman, Medina, George Washington University; Arthur B. Ream, Bowersville, Hahnemann Medical College; William A. French, Jr., Cleveland, Howard University; Bertram F. Averbach, Youngstown, Jefferson Medical College; Howard W. Brettell, Mingo Junction, Jefferson Medical College; Thomas S. Moore, Akron, Jefferson Medical College; Augustus W. H. Brown, Akron, Jefferson Medical College; Louis E. Brown, Jr., Akron, Jefferson Medical College; Louis L. Praver, Cleveland, Jefferson Medical College; William T. Rice, Athens, Jefferson Medical College; Nathan S. Schlezinger, Columbus, Jefferson Medical College; Samuel Schwebel, Youngstown, Jefferson Medical College; John C. Ullery, Dayton, Jefferson Medical College; Virgil W. Weakley, Columbus, Jefferson Medical College; Samuel Brandwan, Jr., Akron, Jefferson Medical College; James I. Collins, Toledo, Loyola University.

Carl A. Marquardt, Cincinnati, Loyola University; John F. Borelli, Hamilton, Marquette University; Edwin R. Deppe, Dayton, New York Homeopathic Medical College; James E. Morgan, Cleveland, Northwestern University; Frederick G. Smith, Marion, Northwestern University; Ellis W. List, Andover, University of Louisville; Jack H. Persinger, Washington C. H., University of Louisville; Wilbur B. Light, Tooawa, University of Minnesota; George P. Sims, Columbus, University of Nebraska; Harold L. Williams, Norwalk, University of Oregon; Roy C. Costello, Cleveland, University of Pennsylvania; Ralph B. Miller, Springfield, University of Pennsylvania; Hart E. VanRiper, Cincinnati, University of Pennsylvania; Alvie C. Walker, Washington, Pa., University of Pennsylvania; Carroll E. Herron, Columbus, University of Pittsburgh; Helen M. Kingsbury, Cleveland, University of Rochester; Kay E. Liber, Alliance, University of Rochester; Harry A. Tagett, Columbus, University of Rochester; Herbert F. Van Epps, Cleveland, University of Rochester; Joseph V. Pischieri, Cleveland, University of St. Louis; Oscar F. Rosenow, Columbus, University of Wisconsin; Charlotte Winnemore, Columbus, Women's Medical College of Pennsylvania; Edwin B. Egli, Cleveland, Yale University.

Reciprocity—Michael H. Barone, Toledo, University of Buffalo; Paul C. Barton, Cleveland, University of Maryland; Ralph J. Beare, Celina, University of St. Louis; Chester A. Bennett, Massillon, University of Louisville; Esther D. Brenneman, Kent, University of Michigan; Burton Clark, Jr., Cleveland, Harvard Medical School; Rudolf O. Cooks, Cleveland, Syracuse University; Roger O. Egeberg, Cleveland, Northwestern University; Arthur C. Ernstene, Cleveland, State University of Iowa; John U. Fauster, Jr., Defiance, University of Michigan; Edward R. Garvin, Toledo, University of St. Louis; Isaac L.

George, Gallipolis, Tulane University; James A. Hamma, Columbus, Jefferson Medical College; John J. Harrison, Napoleon, University of Michigan; Peter W. Hess, Cincinnati, University of Arkansas; Harold F. Hilty, Dayton, Indiana University.

Bernard L. Johnson, Forest, University of Louisville; George W. Johnson, Toledo, Meharry Medical College; Robert L. Johnston, Cincinnati, Rush Medical College; William Katzel, Cleveland, University of St. Louis; Joseph B. Klein, Cleveland, University of Louisville; Morris A. Krakoff, Columbus, Detroit College of Medicine and Surgery; Morris Krutchkoff, Cleveland, Washington University; Frank J. Lacksen, Cambridge, University of Louisville; Harley B. Lehnert, Port Clinton, University of Michigan; Maurice Levine, Cincinnati, Johns Hopkins University; Abe A. Lichtblau, Canton, University of Michigan; Ray H. Long, Cleveland, University of Oklahoma; Perry R. Longaker, Dayton, Johns Hopkins University; Edward E. Lyon, Toledo, Northwestern University.

John W. Marsh, Newark, Bellevue Medical College; James M. McBride, Lima, Indiana University; William M. McLin, Dayton, Indiana University; Mabel Louise Pearce, Painesville, Western Reserve University; Oscar Rimson, Cleveland, Tufts Medical School; Francis J. Robben, Cleveland, University of St. Louis; Arthur M. Rosenthal, Lorain, Indiana University; Helen P. Rowland, Cincinnati, Washington University; Jacob W. Schoolnic, East Liverpool, Rush Medical College; Paul W. Shannon, Hubbard, University of Michigan; Harold P. Shapiro, Toledo, Detroit College of Medicine and Surgery; Joseph L. Sheppe, Proctorville, Maryland Medical College; Harry S. Tucker, Cleveland, University of St. Louis; Joseph L. Vinocur, Cleveland, University of St. Louis; Abbott Y. Wilcox, Jr., Cincinnati, University of Pennsylvania; Samuel H. Winston, Massillon, Queen's University; Floyd D. Yeager, Marion, Detroit College of Medicine and Surgery; Edward A. Zimmerman, Dayton, University of St. Louis; Clarence H. Zurcher, Bellevue, University of Louisville.

Maintenance of Adequate and Systematic Office Records May Solve Some of the Puzzling Business Problems Confronting the Practicing Physician

By WORTH L. HOWARD
Cleveland, Ohio

Many doctors' business problems would be partially solved if their secretaries kept adequate and systematic office records. In the doctors' office there are two types of records; the business and the professional. The secretary should be fully responsible for the business records, and should care for the assignments given her on the professional.

One of the best methods of recording deposits and withdrawals for a small volume of business is to enter them directly into one book called the "Cash Book". All monies received should be deposited in the bank and all disbursements made by bank checks except on very small payments, which should be made from a "Petty Cash" fund. Where this plan of handling receipts and disbursements is followed, a column, headed "Bank Deposits", should be provided on the receipt side (which is the left hand side) and one headed "Bank Withdrawals", on the disbursement side (which is the right hand side). On the first of the month the balance is entered on the receipt side and all monies received for the month should be analyzed as to source; i. e., from patients, operative, fees, personal receipts, etc., and when deposited in bank should be added to the previous bank balance. Each check issued is entered in the bank withdrawal column and distributed according to your chart of accounts. This method of bookkeeping eliminates the entering of detail of the check stubs as the data is entered directly into the cash book when checks are issued. The difference between the two bank columns represents the amount in bank, provided all receipts have been deposited.

In closing the cash book at the end of the month a summary is made of both the receipts and disbursements, and the bank balance reconciled with the statement received from the bank. At the beginning of the next month the cash balance on hand at the close of the previous month is entered on the first line of the next left hand page.

A receipt, bearing serial number, should be made out in duplicate for all monies received; every receipt should be accounted for. If a receipt is made out incorrectly it should be marked "Void" and the original of this receipt should be attached to the duplicate. These receipts should be entered, numerically, in the cash book and posted daily from the cash book to the respective patients' account cards.

An "Information" card should be established

(The accompanying article by Mr. Howard, connected with the Welfare Federation of Cleveland, is the first of a series to be published in *The Journal* on business and legal questions of particular interest and importance to members of the medical profession and their secretaries. The papers reproduced in part in this series comprised a course in business administration presented by the Academy of Medicine of Cleveland in conjunction with the Cleveland Retail Credit Men's Company and are published with their consent and through their courtesy. Because of space limitations in *The Journal*, it has been found necessary in some instances to abstract parts of the presentations made by the lecturers, but this has been done in such a way that the meaning, effect and much of the value of each have been retained—*The Committee on Publication.)*

for every patient. This card should bear the following minimum information:

Date
Name of Patient
Address
Employer's Name
Employer's Address
Referred by
Referred to
Age
Sex
Color.

Space should be provided, on the back of this card, for the recording of the office and doctor's home calls; the date and time of the patient's appointments and service rendered. The secretary should ask the doctor, each morning, for the names of the patients to whom he made night visits. This information is necessary to establish charges for the patients' calls, which are not received by the secretary. The charges, which are to be made to the patients' account cards are taken from the "Information" card, and are posted the following morning. Patients' account cards should bear their name, address, to whom bill is to be sent, terms, and credit information. All charges and credits are posted on this card and the balance due should be figured at the end of each month, at which time a statement is rendered to the patient, from the card, showing the balance due on their account. The doctor should check over these statements before they are mailed to the patients, and in this way acquaint himself with the patients' accounts and also protect himself against fraud.

May I submit, herewith, a proposed chart of accounts:

INCOME	EXPENSE
Income from Patients	Rent
Income from First Aid	Salaries
Income from Operation	Office Supplies
Personal Receipts	Auto Expense
Interest	Doctor's Drawing Account
Dividends	Medical & Surgical Supplies
Rent	Drugs
Miscellaneous	Equipment

Follow-up of Unpaid Accounts

A tickler system should be established for the collection of delinquent accounts and a routine follow-up strictly adhered to. The practice of using the account card for a tickler system should be discouraged. The name, address and amount of bill should be written on a 3x5" card and filed under date when payment was promised by the patient, or, when a follow-up letter is to be mailed. If payment is received on account, a notation should be made on the card to this effect and card should again be filed under date of next payment or follow-up letter. If the account is paid in full the card should be cancelled.

Patients' accounts should be aged every three or six months. This is done by entering the unpaid balances, from all accounts receivable cards, into certain groups, i. e., all unpaid balances under three months, six months, nine months, one year, and over one year; when completed, the total of these five groups should agree with the total amount of the accounts receivable. This statement will enable the doctor to analyze, quickly, the age of the accounts which are due.

Comparative Statements

Comparative statements are prepared to show the increase or decrease as between different periods, of the amounts of the various items which make up the statement. While the increases and decreases of the individual items in themselves afford good material for study and show the trend of the activities as compared with a previous condition, the relation of the increases and decreases to each other are deserving of very careful study, i. e., conditions as they exist in a particular profession, or general conditions affecting the community or the entire country. If a comparative statement of income and expense shows that there is a decrease in cash receipts or increase in expense, or both, the doctor may say, "What can I do about it?" In this connection, patients' accounts should be analyzed for possible collections and pressure should be brought to bear on old accounts. This plan will undoubtedly show a marked improvement in cash reecipts. The expense items should also be scrutinized, to locate items on which there may be reductions or eliminations.

It is proposed, that the secretary prepare, at the close of the month's business, the following statements:

Comparative statement of Collections and Earnings
Comparative statement of Cash Receipts and Expense

Statements should be prepared in detail according to your income and expense accounts and should include the business of:

Present month
Same month last year
Present year to date
Last year to date

It is generally agreed that the graphic chart affords one of the best means for presenting facts, clearly and quickly. A graphic chart showing Earnings versus Collections and Cash Receipts versus Expense, is probably the best means of presenting to the Doctor, a composite picture of his business. The chart should date back at least five years.

There would be a considerable saving made on office forms if the doctors in this city would get together and agree upon a uniform plan for their office records. This would permit the printing of forms in quantities which would greatly lower their cost.

The preceptor system is being used at the College of Medicine, University of Cincinnati. Each member of the medical faculty has one or two freshman students assigned to him and continues to serve as a preceptor for these students throughout their entire medical course.

Payment of Physicians for Services on Implied Contracts, Ownership of X-ray Films, and Practice of Optometry Analyzed in Court Decisions and Attorney General Opinions

Two decisions having to do with suits by physicians to recover compensation for professional services were handed down recently in the Hamilton County Common Pleas Court by Judge Thomas H. Darby.

One was in a suit filed by a physician against a resident of Cincinnati whose child he had attended as a consultant for the attending physician.

Overruling a decree of the Cincinnati Municipal Court in favor of the defendant on the ground that the services of the physician had not been contracted for, Judge Darby held that the consulting physician was entitled to compensation, stating that "a contract to pay arises from implication, where it is reasonably apparent that under the conditions it was necessary or proper for the attending physician to call a consultant as in this case" and where as in this case "the defendant, a parent being responsible for the support of his child, knew the plaintiff was rendering services to his child and by accepting those services made himself liable for them".

The second case followed an automobile accident in which the wife of the driver of the machine was injured and taken to a hospital where an emergency operation was performed to save her life. The husband refused to pay the attending surgeon, contending that there had been no express contract for the services on the part of the physician.

Judge Darby, in ruling in favor of the physician, held that "the defendant was responsible for necessaries for his wife and the services rendered were necessary".

* * *

Attorney General Bettman in an opinion rendered to the commissioners of Seneca County held that there is no legal authority under which county commissioners can recover from the owner of a dog afflicted with rabies which has bitten a person, the amount expended by the county in medical treatment of the victim, whether the owner has obtained a license for such dog or not.

* * *

Another case involving the ownership of *X*-ray films has been decided by the courts of Michigan. The first case (referred to in the July, 1932, issue of *The Journal*) appealed by the Hurley Hospital of Flint created widespread interest because of the fact that it was one of the few cases on record where a clear-cut decision was rendered on this controversial question.

Recently a similar case was decided by the Ingham County (Michigan) Circuit Court to the effect that *X*-ray films are the property of the hospital or the private *X*-ray laboratory in which the examination was made.

Quoting from the court's decision directing a verdict for the defendant physician:

"The undisputed evidence in this case is to the effect that it is customary that such films be retained by the physician who has taken them—retained by him as a part of his record concerning the case; retained, I suppose, on the same basis and on the same theory that he retains his temperature chart that he has made or other record concerning the diagnosis or treatment of a case. That testimony stands undisputed on this record. I think it must be conceded that it establishes an uncontradicted custom touching and concerning the subject matter of this case. And that as a matter of law it must be said that where *X*-ray pictures are taken by a physician under the circumstances such as they were taken by Dr. Pinkham in this case, there is no implied undertaking to turn those films over to the patient."

The court pointed out that there was no evidence to show that the *X*-ray films of themselves had any intrinsic value whatever and that replevin lies to recover only property which has value.

Commenting on the decision, the *Michigan State Medical Journal* declared that the verdict clearly bears out the opinion of *X*-ray specialists "that the interpretation is the all important thing in connection with an *X*-ray examination and that the film or radiograph is simply the basis of the interpretation".

* * *

Some interesting medico-legal angles to radiology, especially the practice of this specialty by technicians and other laymen and the potential danger facing the physician who patronizes such laboratories or laboratories operated by incompetent persons, are discussed by Dr. Carl Scheffel, Miami, Florida, in a recent issue of *Radiology*.

After pointing out that the field of radiology is probably being encroached upon to a greater extent than any other branch of medicine, Dr. Scheffel said:

"When, however, we view our brethren within the medical profession who make possible the continuance of such lay encroachment in the field of radiology by sending patients to such 'technicians', then we become awestricken at the risks thereby assumed from a medico-legal standpoint.

"Obviously, a physician sending a patient to be *X*-rayed by a 'technician' in legal 'no-man's land', as it were, who, of his own accord, has no legal right to take *X*-ray films, then delegates to that 'technician' some of the authority given him by virtue of his own license to practice medicine. This in law, constitutes the creation of an implied relationship of principal and agent, in which the physician becomes the principal, and the 'technician' becomes his agent. * * * While physicians almost daily create implied relationships of principal and agent in connection with assistants of various kinds, both professional and lay, there exists grave doubt as to whether or not physicians appreciate to the extent that they should the responsibilities that arise out of such a relationship.

"With extremely rare exceptions, a principal becomes responsible in law for any wrongdoings of his authorized agents. So far as physicians are concerned who send patients to 'technicians' who have no status as independent contractors, if the patients are injured by such 'technician'-agents, then the referring physician, as the principal, may become liable for damages the patient incurs as the result of being referred by the physician."

* * *

An opinion dealing with the practice of optometry by an individual in more than one county of the state and by an optometrist residing outside of Ohio but doing business in this state was handed down recently by Attorney General Gilbert Bettman.

In his opinion (No. 4263), Mr. Bettman set forth the following interpretations of the Ohio law:

(1) When an optometrist, licensed in Ohio, maintains his principal office in one city and owns and operates another office in another city, which is operated in his own name, but in charge of an employe, who is a licensed optometrist, such owning optometrist is practicing optometry in each city.

(2) When an optometrist, not licensed to practice in Ohio, operates his principal office in another state, maintains an office in Ohio, which is operated by an employe who is a licensed optometrist, such owning optometrist is practicing optometry in Ohio without a license, in violation of Section 1295-33, G. C.

(3) When an optometrist licensed to practice in Ohio advertises two places of business owned by him, one of which is conducted in a second city in charge of an employe, such act is not in violation of Section 1295-31, G. C., or the rules of the State Board of Optometry defining "dishonest conduct".

(4) When an optometrist who is licensed to practice in another state but not in Ohio, and conducts an office in this state in charge of an employe who is a licensed optometrist, such conduct on the part of both the employer and employe is in violation of the rules and regulations of the State Board of Optometry, and on the part of the employer, is in violation of the provisions of Section 1295-22, G. C., which makes it unlawful to practice optometry in Ohio without a license.

(5) When an optometrist conducts offices in two different counties, he is required by the provisions of Section 1295-29, G. C., to have his certificate of license to practice optometry registered with the clerk of the court of common pleas in each such county. Upon failure to so register such certificate he is subject to conviction of a misdemeanor under the provisions of Section 1295-22, which conviction automatically revokes the license of the optometrist under the provisions of Section 1295-31, G. C.

* * *

A decision which termed as "arbitrary and unreasonable and consequently void" certain rules and regulations of the State Board of Optometry was handed down recently by Judge John R. King of the Franklin County Common Pleas Court.

Judge King's decision was rendered in overruling a demurrer of the State Board of Optometry to a suit for equitable relief and an injunction filed by a group of optometrists to prevent the State Board from enforcing rules and regulations prohibiting optometrists to advertise the prices of glasses, frames, mountings, lenses, etc., and prohibiting an optometrist to have any connection with or accept employment from a partnership, firm, association or corporation which is not engaged solely in the practice of optometry.

Relative to the advertising phase of the question, Judge King declared: "Honest advertising of any product is to be encouraged, not condemned or prohibited. It enables the honest tradesman to establish himself and his business and insure to the public the best product at the lowest price.

"This right ought not to be interfered with unless such is necessary for the safeguarding of the welfare, safety or morals of the people.

"Any regulations either by the General Assembly or an administrative board in the conduct of one's business or his right to earn a living which does not directly relate to the public safety, health or morals, is arbitrary and unreasonable and consequently unenforceable.

"Such a regulation clearly is not responsive to any demand of the public. On the contrary such a regulation, if permitted to stand, will destroy competition and will result in price fixing and monopoly."

Judge King in holding that the rule governing an optometrist's connection with a corporation is void, said:

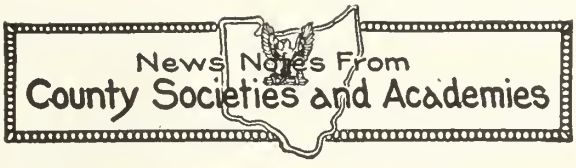
"It must be borne in mind that department

stores throughout the state have for many years conducted optometric departments exclusively in charge of licensed optometrists. Throughout these years it has been expressly sanctioned by the Board of Optometry and not prohibited by any provision of the law nor was so questioned by the board until a recent enactment of rules 6, 7 and 8.

"If such practice was proper prior to and on October 3, 1927, when such procedure was expressly sanctioned by the board, what circumstances or conditions have rendered it improper, necessitating a sudden change of the rule, thereby causing a great number of duly licensed and registered optometrists to sever connections which they have spent much time and effort in establishing?

"What difference does it make so far as the health, safety and physical welfare of the people are concerned in the adjustment of eye glasses whether they go to a department store or to a room occupied by an individual, so long as such optometrical work is performed by an individual competent and qualified under the law to perform such services?

"We conclude that the rules promulgated by the board with reference to the conduct of the business of optometry by licensed optometrists in connection with lawful corporations is arbitrary and unreasonable and consequently void."



First District

Adams County Medical Society met in regular session June 15 at West Union. The program consisted of three scientific papers. Dr. F. C. Beeks, Portsmouth, spoke on "Urology Concerning the General Practitioner". A paper on "Intubation of the Larynx" was read by Dr. G. F. Thomas, Peebles, and Dr. Henry L. Woodward, Cincinnati, presented one on "Management of Difficult Presentations". A luncheon was served at the North Side Hotel following the meeting.—News Clipping.

Butler County Medical Society held an all-day outing June 22 at the White House, near Middletown. About 40 members were present for the banquet which followed an afternoon of athletic events. A number of physicians from Warren County were guests.—News Clipping.

Clermont County Medical Society met June 15 at Batavia with a good attendance. The program was presented by two guest speakers. Dr. David A. Tucker, Jr., associate professor of contagious diseases, College of Medicine, University of Cincinnati, addressed the society on "Effects of Prolonged Use of Insulin", and Dr. Harold F. Downing, assistant professor in pediatrics, of the same school, read a paper on "Early Diagnosis and Treatment of Acute Poliomyelitis".—Allan B. Rapp, M.D., Secretary.

Clinton County Medical Society at its meeting on June 7 at Wilmington was entertained by a scientific program of case reports, presented by the following: Dr. C. A. Tribett, "Mumps with No Parotid Symptoms with Bilateral Orchitis"; Dr. V. E. Hutchens, "Pernicious Anemia Treated with Subcutaneous Injections of Liver Extract"; Dr. S. A. Crabtree, "Hodgkins' Disease"; Dr. Robert Conard, "Case of Trichomonasis Vaginalis"; Dr. L. H. Fullerton, "Version, with Baby Crying Before the Head was Delivered"; Dr. Kelley Hale, "Infestation of Appendix with Pin Worms"; Dr. E. C. Kinzel, "Pregnancy with Umbilical Hernia"; Dr. F. A. Peelle, "Dislocated Shoulder". Dr. Ben R. McClellan, Xenia, concluded the program with a talk on "Costs of Medical Care" and presented a case report on "Adhesions of Parietal Peritonium Associated with Inflammation of Uterine Adenexia".—W. L. Regan, M.D., Secretary.

Warren County Medical Society met in regular session at Lebanon on June 7. The guest speaker was Dr. E. O. Smith, Cincinnati.—News Clipping.

Second District

Greene County Medical Society held its regular meeting July 7 at Xenia. Dr. Robert Carothers and Dr. Ralph Carothers, both of Cincinnati, addressed the society on "Fractures". Motion pictures, lantern slides and *X*-ray plates were shown illustrating the use of local anesthesia in the reduction of fractures and the application of casts. A general discussion followed the addresses. Luncheon was served at the Iron Lantern following the meeting.—H. C. Schick, M.D., Secretary.

Third District

Auglaize County Medical Society met in the Commercial Club rooms at Minster on June 9 in regular bi-monthly session with 13 members and two guests, Dr. R. E. Paul, Botkins, and Dr. W. H. Thompson, Celina, present. After reports on the annual meeting of the State Association at

Dayton were presented by Dr. R. C. Hunter and Dr. C. C. Berlin, the special feature of the program was presented by Dr. Karl D. Figley, Toledo, who spoke on "Practical Treatment of Hay Fever and Pollen Asthma". Considering the three successive invasions of each year as (1) tree asthma, (2) grass hay fever, or rose fever, and (3) ragweed hay fever, Dr. Figley outlined the methods of treatment as preventive, mechanical, local, internal medication and pollen extract. This timely and exhaustive consideration of the subject was interestingly illustrated by microscopic exhibits of pollen grains and by practical application of pollen extracts for both diagnosis and treatment to hay fever patients present at the meeting. A social hour followed the program, when refreshments were served. Plans were made for the next meeting on August 11 at St. Marys. —Charles C. Berlin, M.D., Secretary.

Hardin County Medical Society was entertained on July 1 by the medical profession of Ada. The meeting was held at the Ohio Northern University restaurant. Dr. P. I. Tussing, Lima, was the guest speaker.—News Clipping.

Logan County Medical Society held a dinner meeting June 3 at the Logan Hotel, Bellefontaine. Dr. W. C. Breidenbach of the Stillwater Sanatarium, Dayton, addressed the society and presented histories of about 20 cases of tuberculosis examined at the tuberculosis clinic being held in Bellefontaine under the auspices of the medical profession and city health department.—News Clipping.

Seneca County Medical Society transacted routine business and held a round-table discussion at its regular meeting at the Shawhan Hotel, Tiffin, on June 16.—News Clipping.

Van Wert County Medical Society met June 27 with Dr. A. T. Rank of Cavett as host. Papers were read by Dr. R. J. Morgan and Dr. C. G. Church. A luncheon and smoker followed the program.—News Clipping.

Fourth District

Wood County Medical Society met in regular session June 16 at the Woman's Club, Bowling Green. Following a dinner, the society was addressed by Dr. N. Worth Brown, Toledo, on "Abdominal Symptoms in Cardiac Disease and the Relation of Acute Indigestion to Heart Disease". The paper was well presented and enjoyed by all. An open discussion followed.—R. N. Whitehead, M.D., Correspondent.

Fifth District

Geauga County Medical Society at its meeting on June 29 at Chardon was addressed by Dr. Scott C. Runnels, Cleveland, on "The Facts of Maternal Mortality". Dr. Runnels based his remarks on an extensive study of maternal deaths in Cleveland and emphasized the falseness of statements made by some lay journals that the American maternal mortality rate is appalling, citing statistics gathered in his study to refute this charge.—Isa Teed Cramton, M.D., Secretary.

Lorain County Medical Society held its annual outing on July 20 at the Lorain Country Club. In the afternoon golf and bridge were enjoyed by the members and their wives. In the evening a dinner was served, followed by addresses by Dr. C. L. Cummer, Cleveland, president-elect of the State Association, and Dr. J. A. Tuckerman, Cleveland, chairman of the Committee on Medical Defense of the State Association.—News Clipping.

Sixth District

Mahoning County Medical Society held its semi-annual business meeting on June 28 at the Youngstown Club. Following the dinner, F. Rollin Hahn, Youngstown attorney, addressed the society on "Medico-Legal Problems". Committee reports were presented and other business transacted.—Bulletin.

Seventh District

Annual meeting of the Seventh District Medical Society was held June 17 at the Union Country Club near Dover. About sixty physicians from the various counties in the district attended. At the business session, Dr. R. H. Wilson, Martins Ferry, was elected president, and Dr. F. R. Dew, St. Clairsville, secretary, for the coming year. It was decided to hold the 1933 meeting at the Belmont Hills Country Club, St. Clairsville. The scientific program consisted of the following papers: "Acute Obstruction", Dr. I. B. Harris, Columbus; "Treatment of Prevalent Skin Diseases", Dr. C. J. Shepard, Columbus; "Facts About the Injection Treatment of Internal Hemorrhoids", Dr. Wells Teachnor, Columbus. The concluding addresses on the program were made by Dr. H. M. Platter, Columbus, president of the State Association, and Dr. E. B. Shanley, New Philadelphia, councilor of the Seventh District.—News Clipping.

Columbiana County Medical Society at its meeting on June 14 at Lisbon was addressed by Harrison L. McCarthy, Salem attorney on "The Doctor and the Law".

The July meeting of the society was held on July 14 at the East Liverpool Country Club. A golf tournament was held in the afternoon. Dinner was served at 6 p. m., followed by an address by Dr. Walter Donaldson, secretary of the Medical Society of the State of Pennsylvania. Dr. Donaldson spoke on "Improved Relations Between the Public and the Organized Medical Profession". Members of the dental profession were guests of the physicians.—T. T. Church, M.D., Secretary.

Eighth District

Annual meeting of the Eighth District Medical Society was held June 23 at the Rocky Glen

Sanatorium, McConnelsville, with H. A. Phillips, superintendent, and Dr. Louis Mark, medical director, as hosts. More than 150 physicians attended. Following a luncheon, short talks were made by Mr. Phillips and Dr. Mark. Dr. D. G. Ralston, McConnelsville, the toastmaster, presented Dr. H. M. Platter, Columbus, president of the State Association who spoke on organization activities and on the necessity for maintaining strong medical organization as well as high professional ideals. Telegrams of regret at being unable to attend the gathering were read from Dr. C. L. Cummer, Cleveland, president-elect of the State Association; Governor George White and David S. Ingalls, Republican nominee for governor. The luncheon session also was addressed by Dr. H. G. Southard, State Director of Health, Rev. F. G. Fowler, superintendent of White Cross Hospital, Columbus, and Miss Margaret Riley, superintendent of University Hospital, Columbus. At the business session, Dr. Ward G. Coffman, Zanesville, was elected president for the next year, and Dr. Ralston, secretary. It was decided to accept Mr. Phillips' invitation to hold next year's meeting at Rocky Glen. After several vaudeville skits and a social hour, a scientific program was presented. Papers were read by the following: Dr. Albert D. Frost, Columbus, "Cooperation Between the General Practitioner and the Oculist"; Dr. E. E. Hamilton, Columbus, "Some Observations on Colitis"; Dr. Charles A. Doan, Columbus, "The Basis of Prognosis in Disease"; and Dr. R. W. Kissane, Columbus, "Habits in Heart Disease". Dr. E. R. Brush, Zanesville, councilor of the Eighth District, was present and assisted in arranging for the meeting.—News Clipping.

Athens County Medical Society met in regular session at Athens on June 6 with 27 in attendance. Following a luncheon, Dr. A. G. Helmick, Columbus, addressed the society on "Diarrheal Diseases of Children".—News Clipping.

Fairfield County Medical Society met on June 14 at the Stoutsville Inn, Stoutsville. Dr. C. H. Creed, superintendent of the Athens State Hospital, was the guest speaker, talking on "Brain Tumor".—News Clipping.

Perry County Medical Society met in regular session on June 20 in the Junction City-Jackson Township high school building. A representative of the American Heart Association addressed the society on "Valves of the Heart in Action". A discussion on spinal anesthesia also was conducted. Slides were used to illustrate both subjects. The program was arranged by Dr. W. D. Porterfield, Junction City.—Bulletin.

Ninth District

Hocking County Medical Society was addressed by Dr. James Rector, Columbus, at its meeting on June 28 at Logan. There was a good attendance.—News Clipping.

Scioto—Annual business meeting of the Hempstead Academy of Medicine was held July 11 at the Recreational Hall of the Nurses' Home. A buffet luncheon was served following the meeting.—Bulletin.

Tenth District

Knox County Medical Society was entertained at a luncheon meeting on June 29 by Dr. F. C. Anderson, superintendent of the Mt. Vernon Sanatorium. Fifteen members were present. Routine business was transacted and a round-table discussion held.—News Clipping.

Madison County Medical Society held a luncheon meeting on July 1 at the London Country Club. A paper on "Diverticulum of the Esophagus" was presented by Dr. Andre Crotti, Columbus, and the discussion was led by Dr. C. W. McGavran, Columbus.—News Clipping.

New Books Received

Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association for 1931. Cloth. Price, $1.00. Pp. 100. Chicago: American Medical Association.

This volume contains the collected reports of the action of the Council on Pharmacy and Chemistry on all products which have been found unacceptable or which have been omitted from New and Nonofficial Remedies during the past year. It contains also the special reports authorized by the Council during the year and preliminary reports on articles which show promise but which are not ready for admission to New and Nonofficial Remedies nor suitable for general use by the medical profession.

Fertility and Sterility in Marriage. Their Voluntary Promotion and Limitation. By Th. Van DeVelde, M.D., formerly director of the Gynecological Clinic at Haarlem, Holland. Translated by F. W. Stella Browne. This book, because of its scientific character and because of legal restrictions placed upon its distribution, is available only to duly licensed physicians on their written or authorized order. Covici-Friede, Medical Books, New York.

The Genius of Louis Pasteur, by Piers Compton; the life and work of the brilliant French scientist. The MacMillan Company, 60 Fifth Avenue, New York. Price, $4.50.

Dr. Henry S. Plummer, Rochester, Minn., was elected president of the American Society for the Prevention of Goiter at the recent meeting of that organization at Hamilton, Ontario.

The 1934 annual meeting of the National Tuberculosis Association will be held in Cincinnati, it has been decided by the executive committee of that organization.

Deaths in Ohio

E. F. Collins, M.D., Akron; Starling Medical College, Columbus, 1879; aged 82; died July 2 at the home of his son at Benton of paralysis following a prolonged illness. He had practiced for many years at Independence, near Cleveland, before moving to Akron. He leaves his widow and three daughters besides one son.

Willard Thomas Conley, M.D., Dresden; Medical College of Ohio, Cincinnati, 1887; aged 71; died June 11 of heart disease. Dr. Conley had practiced in Dresden for the past 40 years. He leaves two daughters, one brother and one sister.

John J. Fitzsimmons, M.D., Clarkson; Starling Medical College, Columbus, 1895; aged 64; former member of the Ohio State Medical Association and the American Medical Association; died June 20 of heart disease. Dr. Fitzsimmons, a native of Columbiana County, practiced in Calcutta for 30 years, moving to Clarkson two years ago. He was a member of the Masonic Lodge. Surviving are his widow, one son, two daughters, two sisters and one brother.

John M. Floor, M.D., Petersburg; Eclectic Medical College, Cincinnati, 1875; aged 79; died July 4 from injuries sustained in an automobile accident June 28. Dr. Floor was born at Berlin Center. Following his graduation from medical school, he located at New Middletown, moving to Petersburg in 1885. Surviving are his widow and one daughter.

Edgar M. Freese, M.D., Columbus; College of Medicine, Ohio State University, 1908; aged 46; former member of the Ohio State Medical Association and the American Medical Association; died June 13 from wounds received when a revolver he was cleaning was discharged, while visiting on a ranch at Medora, North Dakota. Dr. Freese was chief of the surgical staff of the Hocking Division of the C. & O. Railroad. He leaves his widow, one son, one stepdaughter, one brother and his father.

Guy G. Giffen, M.D., Dayton; College of Medicine, University of Cincinnati, 1911; aged 44; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died June 17 of sarcoma. Dr. Giffen, a native of Oxford, received his early education in the Hamilton public schools. After graduation from medical school, he took post-graduate work at Johns Hopkins University. Sixteen years ago he located in Dayton where he specialized in urology. During the World War he served overseas as a lieutenant in the medical corps. Dr. Giffen, a former secretary of the Montgomery County Medical Society, was a member of the American Urological Society, the Methodist Episcopal Church, the Dayton Triangle Club, Lions Club, the Pythian and Masonic lodges. Surviving are his widow, two sons and his parents.

Elmer G. Gray, M.D., McComb; Columbus Medical College, 1892; aged 65; died June 27 of heart disease. Dr. Gray moved to McComb from North Robinson six years ago. Surviving are his widow, three sons, two daughters, one brother and one sister.

James W. McMurray, M.D., Marion; Starling Medical College, 1897; aged 65; member of the Ohio State Medical Association and the American Medical Association; died June 26 of Bright's disease. Dr. McMurray, a native of Marion, was active in military and civic affairs. Shortly after graduation from medical school, he enlisted in Company G, Fourth Regiment, Ohio National Guard and saw active service in Porto Rico during the Spanish-American War. He retired from the National Guard in 1912 with the rank of major in the medical corps. During the World War he was on active duty service at Camp Greenleaf, Georgia. Dr. McMurray was the first president of the Marion Kiwanis Club and was a lieutenant governor of Division No. 4 of that organization. He was for more than 25 years a member of the Association of Military Surgeons. Dr. McMurray, who served two terms as president of the Marion County Academy of Medicine, was a member of the American Association of Roentgenology and Radiologists and various Masonic orders. Surviving are his widow, two daughters, two step-sons, one sister and his mother.

Charles E. Neal, M.D., Cincinnati; College of Medicine, University of Cincinnati, 1913; aged 63; former member of the Ohio State Medical Association and the American Medical Association; died May 26 following a long illness. Dr. Neal, a native of Cincinnati, had practiced medicine there for the past 20 years. He was a 32nd Degree Mason. Surviving are his widow, two sons, one sister and one brother.

James McMeen Stewart, M.D., Fremont; Bellevue Hospital Medical College, New York, 1869; aged 90; died June 9 of pneumonia. Dr. Stewart sustained a broken hip when he fell at his home several days before his death. Dr. Stewart was born in Seneca County and in 1854 moved with

his family to Wood County. When the Civil War broke out, Dr. Stewart enlisted in Company I, 111th Regiment. Following the war he entered Baldwin University, Berea, graduating with a degree in pharmacy. Following graduation from medical school, he began active practice at Fremont. In 1871 he moved to Oak Harbor where he practiced until 1893 when he returned to Fremont. Dr. Stewart retired in 1927 after 58 years of active practice. He was a Mason and a member of the Pythian Lodge, and the G. A. R. Surviving is one daughter with whom he made his home.

Joseph A. Turner, M.D., Columbus; College of Medicine, Ohio State University, 1911; aged 45; member of the Ohio State Medical Association and the American Medical Association; died June 25 of cirrhosis of the liver. Dr. Turner was a member of the Exchange Club, Elks Lodge and the American Legion. He leaves his parents, two brothers and one sister.

Charles James Scott, M.D., Marietta; Jefferson Medical College, 1881; aged 74; member of the Ohio State Medical Association and the American Medical Association; died June 23 of pneumonia. Before locating in Marietta in 1913, Dr. Scott had practiced at Parkersburg, West Virginia, and Denver, Colorado. He was a past president of the Washington County Medical Society and was active in church work and in the Masonic Lodge. Dr. Scott was on the medical staff of the Baltimore & Ohio Railroad and was a member of the American Association of Railroad Surgeons. He leaves one daughter with whom he made his home.

Joseph Sykora, M.D., Cleveland; School of Medicine, Western Reserve University, 1875; aged 79; died June 9. Dr. Sykora was born in Cleveland of Bohemian parents. After completing his medical course, he was appointed a district physician, the first in Cleveland, and made many of his calls on the foreign residents of Cleveland on horseback. He was a Mason and a member of the Knights of Pythias. Surviving are his widow, one son and five daughters.

KNOWN IN OHIO

Chase P. Ambler, M.D., Asheville, North Carolina; School of Medicine, Western Reserve University, 1889; aged 67; a Fellow of the American Medical Association; died June 5 following a long illness. Dr. Ambler was a native of Salem, Ohio. For a time, 1893-1896, he conducted a private practice in Canton. Since then he had been engaged in tubercular sanitarium activities in Asheville, where he was active and prominent in medical and civic circles. He leaves his widow, two daughters and two sons, Dr. John V. Ambler, Cleveland, and Dr. Arthur C. Ambler, who was associated with him at Asheville.

John Davis, M.D., Asheville, North Carolina; Ohio Medical University, Columbus, 1894; aged 63; former member of the Ohio State Medical Association; died July 5. Dr. Davis, who formerly practiced at Wilmington, had been on the staff of the Veterans Hospital at Asheville for the past eight years.

Elmer E. Flickinger, M.D., Beverly Hills, California; Homeopathic Medical College, Cleveland; aged 72; died May 18 of heart trouble. Dr. Flickinger formerly resided in Willoughby, Ohio. He leaves two sons and two daughters.

E. J. Lauber, M.D., San Leandro, California; Toledo Medical College, Toledo, 1909; aged 47; died June 2 of heart disease. Dr. Lauber had practiced in Defiance until 1924. His parents reside at Archbold and a sister at Wauseon. He had practiced at Ridgeville Corners before moving to Defiance.

Orlando H. Petty, M.D., Philadelphia; Jefferson Medical College, 1904; aged 58; a Fellow of the American Medical Association and a member of the American College of Physicians; died of a self-inflicted wound. Dr. Petty was a native of Harrison County and received his early education in the schools of Harrison and Guernsey counties. Dr. Petty was a holder of the Congressional Medal awarded for valor while serving in a dressing station behind the lines in France. He had been decorated for his military service by several foreign allies.

Clarence F. Schiltz, M.D., American Falls, Idaho; Ohio Medical University, Columbus, 1900; aged 55; a Fellow of the American Medical Association; died June 24 of appendicitis. Dr. Schiltz was born at New Berlin, now North Canton, and practiced medicine in Canton before moving to Idaho 28 years ago. He leaves two brothers of Canton, his widow, another brother and two daughters.

Samuel C. Waters, M.D., Middletown, Indiana; Starling Medical College, Columbus, 1881; aged 71; Fellow of the American Medical Association; died June 24. Dr. Waters was a native of Kenton. He leaves his widow, a foster daughter and one sister.

Some idea of the growth of the hospital field is gleaned from a statistical report recently compiled from the records of Mt. Sinai Hospital, New York City, over a period of 73 years. The report showed that in 1857 a total of 216 patients were treated in the hospital and that hospital maintenance cost $9,000. It had no Out-patient Department at that time. In 1930, 12,179 patients were treated in the hospital and 222,489 consultations held in the Out-patient Department, the maintenance for that year amounting to $1,785,244.23.

NEWS NOTES of OHIO

Akron—The Doctors' Symphony Orchestra of Akron gave its 38th and final concert of its sixth season at the Springfield Lake Sanitorium on June 12. According to the director of the orchestra, Dr. A. S. McCormick, the past season was the most successful in the history of the organization. Concerts were given for the Summit County Medical Society, the Children's Hospital, Peoples' Hospital, Summer Home for the Aged, and at the Uniontown celebration honoring Dr. M. M. Bauer, in addition to the concluding concert at the Springfield Lake Sanatorium. Rehearsals for the seventh season will begin in September, the personnel of the orchestra having enlarged to 39.

Canton—A banquet was given recently by the Canton Medical Library Society at the Canton Club for physicians and their wives. The guests of honor were Drs. E. J. March, E. P. Morrow, M. M. Bauer, G. A. Kelley, A. W. Budd and Seth Hattery. Each of these veteran practitioners, representing approximately half a century of service respectively, contributed interesting glimpses into the lives of the family doctors of other days in brief talks following the dinner. They were introduced by Drs. L. A. Buchman, J. B. Dougherty, E. O. Morrow, C. A. Lamont, J. E. Purdy and R. A. Pumphrey. Portraits of three deceased members of the society were presented and received on behalf of the society by Dr. H. Welland. Dr. J. P. DeWitt, on behalf of relatives, presented portraits of Dr. A. C. Brant and Dr. E. D. Brant, and Dr. Lister Pomerene presented a portrait of the late Dr. Harry Pomerene. Arrangements for the banquet were in charge of Dr. John M. Van Dyke, president of the society.

Columbus—Dr. W. A. Eshelman is convalescing from a recent serious illness at his country home, Anderson, Indiana.

Germantown—Dr. George W. Bachman, son of Mrs. George Bachman of this place, has been appointed director of the School of Tropical Medicine, San Juan, Porto Rico.

Urbana—Offices for general practice have been opened here by Dr. Lewis Inskeep, formerly an intern at the Springfield City Hospital.

Massillon—Dr. R. R. Reynolds talked on "Diseases of the Head" before a recent meeting of the local Rotary Club.

Toledo—Dr. Thomas Heatley is the golf champion of the Toledo Academy of Medicine. He won the championship at the recent tournament of the Academy at the Sylvania Country Club.

Youngstown—Dr. Claude B. Norris has been elected president of the Pittsburgh Dermatological Society.

Wapakoneta—Announcement has been made by Dr. Clyde W. Berry, formerly of Portsmouth and recently an intern at the Miami Valley Hospital, Dayton, of the opening of offices for general practice here.

Wellston—Members of the local Rotary Club were addressed recently by Dr. C. H. Creed, superintendent of the Athens State Hosiptal.

Oberlin—Dr. Floyd M. Bond, a graduate of Rush Medical School in 1931, has become an associate of Dr. R. D. A. Gunn of this city.

Bethel—Dr. W. E. Thompson, believed to be the oldest physician in the country in active practice, celebrated his 97th birthday on July 6.

Akron—Dr. Thomas Cunningham, for the past two years resident surgeon at the Akron City Hospital, has opened offices for private practice here.

Norwalk—Dr. H. L. Williams has been named city physician, succeeding Dr. C. L. Bell.

Bellaire—Dr. F. S. Wright has returned from the East where he took post-graduate work at New York City and Philadelphia.

Washington C. H.—Dr. S. E. Boggs has been named physician at the county jail, succeeding the late Dr. Roy E. Brown.

Columbus—Elizabeth M. Myers, previously associated with Dr. D. J. Davis, dean of the University of Illinois Medical School and Dr. I. Pilot, professor of pathology at the same institution, as their research bacteriologist, has opened a bacteriological and clinical laboratory at 206 East State Street.

Massillon—Dr. Fred L. Rhodes has announced the opening of offices here for the general practice of medicine and surgery. He was for 12 years assistant superintendent at the Massillon State Hospital.

North Fairfield—Dr. P. L. Gray, formerly of Portsmouth, has opened offices here.

Middletown—Dr. Selden Hamilton, who recently completed his internship at the Miami Valley Hospital, Dayton, has become an associate of his father, Dr. N. A. Hamilton, here.

Allianee—Dr. W. E. Unger has been named to attend the indigent sick of Washington Township, this county.

Marion—Dr. S. W. Mattox was elected second vice president of the National Eclectic Medical Association at the annual meeting of the organization at Little Rock, Arkansas.

New Bremen—Dr. Ernest W. Ekermeyer, son of the late Dr. M. S. Ekermeyer of this place and the ninth member of his family to enter the medical profession, has been named resident physician at the Children's Hospital, Iowa City.

Sandusky—Dr. Emil J. Meckstroth, formerly of Dayton, has opened offices here.

Youngstown—Announcement has been made of the marriage of Miss Mathilda J. Meritzer and Dr. Morris S. Rosenblum, both of this city.

Cincinnati—Dr. L. Howard Schriver was a recent speaker before the local Lions' Club.

Cleveland—Dr. Sara S. Marcus, president of the Women's Medical Society of Cleveland, is taking three months post-graduate work at Vienna.

New London—Dr. G. W. Jacoby has returned from the Mayo Clinic where he took post-graduate work.

Columbus—Dr. Delbert A. Minder has been appointed a city physician.

Sandusky—The golf team of the Erie County Medical Society defeated a team from the Toledo Academy of Medicine here recently, 22 to 17.

Columbus—Dr. Jonathan Forman has been appointed by Dr. Mortimer Herzberg, Cincinnati, president of the Ohio Society of Clinical and Laboratory Diagnosis, as chairman of a committee which is working with a similar committee of the Ohio Embalmers' Association to stimulate interest of embalmers in the desirability and importance of autoposies and to bring about cooperation between physicians doing autoposies and embalmers.

Cleveland—The board of trustees of Western Reserve University has accepted a grant of $25,000 from the Rockefeller Foundation to be used for a scientific study of whooping cough by the Department of Medicine, in cooperation with Lakeside Hospital. The study will be conducted under the direction of Dr. Gerald S. Shibley, associate professor of medicine, and will include an effort to identify definitely the germ causing whooping cough and to develop methods of prevention, methods of accurate diagnosis, and means of specific treatment.

Lima—Plans are being completed for the annual series of Post-Graduate Lectures of the Academy of Medicine of Lima and Allen County, to be given the last week in September by Dr. Julius Bauer, professor of medicine, University of Austria. Dr. Bauer also will lecture in Milwaukee, Chicago and Toledo. It has been announced that any medical society interested in securing Dr. Bauer's services while in this country, should correspond with Dr. E. C. Yingling, president of the Lima Academy, Old National Bank Building, Lima.

Lima—Dr. A. N. Wiseley, this city, has been elected alumni trustee of Ohio Northern University for a term of five years.

Cleveland—By action of President Robert E. Vinson, Dr. John Pascal Sawyer, senior member of the medical faculty, Western Reserve University, has been named professor emeritus. Dr. Sawyer entered the university as a student in 1879 and after two years spent abroad after graduation, joined the faculty of the institution. He had been professor of physiology for many years.

Cincinnati—Dr. E. A. Baber, superintendent of the Longview State Hospital, has been elected president of the Cincinnati Rotary Club.

Ironton—For the fourth time in 35 years the name Marting has been inscribed on a diploma from the College of Medicine, University of Cincinnati. The latest Marting diploma was awarded to Miss Esther C. Marting, who completed her medical work there this year. Dr. William F. Marting, her father, received his medical degree from the University of Cincinnati, College of Medicine, then the Medical College of Ohio, in 1897. In 1927, Dr. Anna Marting, a daughter received her degree from the institution, and in 1929 Dr. Miriam R. Marting, another daughter, was graduated there.

Lodi—Mrs. Clarice Whitacre, wife of Dr. J. G. Whitacre, Lodi, was one of five women who received the degree of doctor of medicine from Western Reserve University this year. After a trip abroad, she will become associated with her husband in active practice.

Hamilton—Dr. Louis Schneider, graduate in medicine at the University of Cincinnati in 1930 and for the past year engaged in post-graduate work in tuberculosis at Cincinnati, has opened offices here.

Minerva—Dr. Ray A. Bohl, who recently completed his internship at the Akron City Hospital, has opened offices here.

Columbus—Dr. W. H. Pritchard, superintendent of the Columbus State Hospital, has recovered from a recent major operation and has resumed his duties at the institution.

Columbus—Dr. Isabel A. Bradley, assistant physician at the Columbus State Hospital, has resumed her duties after a year's leave of absence spent abroad visiting mental institutions.

Cincinnati—Dr. and Mrs. Louis Feid, Jr., and daughter, Barbara, are on a three-months' vacation tour of Europe.

HOSPITAL NOTES

—The following graduates of the School of Medicine, Western Reserve University, class of 1932, have accepted intern appointments in the following institutions:

Cleveland City Hospital: J. Robert Andrews, Kent; Glenn E. Chamberlin, Twinsburg; Theodore A. Coffin, Kansas City, Mo.; Paul E. Pifer, Reynoldsville, Penna.; Taylor Smith, Lovelock, Nevada; Antonio S. Broglio, Cleveland; Curtis Ferbert Garvin, Cleveland; Robert Henry Hoecker, Cleveland; Elizabeth S. Hutchison, Cleveland, and Guy H. Williams, Cleveland.

Lakeside Hospital, Cleveland: Orange Van Calhoun, Birmingham, Iowa; William W. Bartholomew, Cleveland Heights; George Lawrence Evans, Cleveland Heights; and Bert Allen Treister, Cleveland.

St. Alexis Hospital, Cleveland: Patsie F. Briola, Ambridge, Penna.; Robert E. Bowman, Cleveland; Edwin A. Jirouch, Cleveland, and John W. Viktoryn, Cleveland.

Lutheran Hospital, Cleveland: Wayne E. Brown, Sandusky.

St. Luke's Hospital, Cleveland: Stanley N. P. DeVille, Meadville, Penna.; Joseph M. Gledhill, Warren, and Howard Stephens, Cleveland.

Mt. Sinai Hospital, Cleveland: Joe I. Goodman, Cleveland; Reuben Ralph Meier, Cleveland; Harold Rand, Cleveland; and Reuben Straus, Cleveland.

Charity Hospital, Cleveland: Paul A. Mielcarek, Berea; Lester Shupe, Fairburg, Nebraska; Harold K. Goler, Cleveland; Theodore A. Gross, Cleveland; Karl J. Simon, Cleveland; and Daniel F. Toth, Cleveland.

Akron City Hospital: Wendell T. Bucher and A. Ralph Keirn of Akron.

Springfield City Hospital: Karl E. Kimber of Springfield, Ohio.

Cincinnati Jewish Hospital: Sidney Ralph Stone, Cleveland.

St. Francis Hospital, Evanston, Illinois: George Turner Court, Gridley, Illinois.

Presbyterian Hospital, Philadelphia: Arch Haigford Gould, Harmony, Arkansas.

Peter Bent Brigham Hospital, Boston: William Richard Hallaran, Cleveland.

Columbia Hospital, Pittsburgh: Laura Mary Hobbs, Miami, Florida.

Wesley Memorial Hospital, Atlanta, Georgia: William Jennings Horger, East Liverpool.

Boston City Hospital: Harold J. Jeghers, Mt. Vernon, New York.

Grasslands Hospital, Valhalla, N. Y.: John E. Longnecker, Struthers, and Dr. Lloyd M. Snively, Justus.

Ohio Valley General Hospital, Wheeling, W. Va.: Robert Harrison McCommon, Shadyside.

Western Pennsylvania Hospital, Pittsburgh: William Graham McLaughry, Mercer, Penna.; and Donald Y. Shaffer, New Brighton, Penna.

Baltimore City Hospital: George Daniel Morse, Coshocton.
Sinai Hospital, Baltimore: Louis S. Zwick, Cleveland.
Montefiori Hospital, New York City: Norman Reider, Canton.

St. Luke's Memorial Ponce Hospital, Porto Rico: Philip M. Reilly, Central Aguiere, Porto Rico.

Gorgas Hospital, Ancon, Panama, Canal Zone: Russell Dean Steele, Cleveland.

—Resident physicians and interns have been appointed at a number of Cleveland hospitals as follows:

University Hospital Group (Lakeside, Maternity, Babies' and Children's and Rainbow)—Interns: James H. Bahrenburg, Western Reserve; J. D. Marsh, Western Reserve; Heintz Kuraner, Kansas University; Theodore Berg, Colorado University; Rowell R. Stephens, Indiana University; Margaret O'Neal, Western Reserve; Marguerite B. Richards, University of Minnesota; J. K. Folger, Long Island College Hospital; W. A. Branbelberry, Western Reserve;; W. A. Sommerfield, Paul Harris, Vanderbilt University; Morris A. Simon, J. C. Leonard, Yale University; J. Morris Horn, University of Pennsylvania; J. H. Harrison, University of Virginia; William W. Bartholomew, Western Reserve; John T. Carmody, Yale; W. H. McGraw, Western Reserve; O. V. Calhoun, Western Reserve; Roscoe M. Needles, State University of Iowa; J. Neill Garber, Indiana University; Wendell J. Thomson, Columbia University; George L. Evans, Western Reserve; Bert A. Treister, Western Reserve.

St. Alexis Hospital—Interns: Augustus J. Baker, St. Louis University; Robert E. Bowman, Western Reserve; Patsie E. Briola, Western Reserve; Edwin A. Jirouch, Western Reserve; Roy H. Thomson, Ohio State; John W. Viktoryn, Western Reserve; Louis E. Bubna, University of Rochester, and J. Grafton Sieber, Jr., Temple University.

Residents: James W. Ockington, St. Louis University; James E. Slivka, Western Reserve, and Joseph V. Pischieri, St. Louis University.

Woman's Hospital—Interns: Ruby D. Hicks, University of Buffalo; George B. Nelson, George Washington University; Malvina L. Lemmle, University of Michigan. Resident: Fred K. Kelly.

St. Ann's Maternity Hospital—Residents: Edward W. Lakner, University of Michigan; Melvin F. Yeip, Western Reserve.

St. John's Hospital—Residents: W. J. Fornes, St. Louis University; J. D. Walters, Ohio State, and George J. Greene, Georgetown University.

Interns: Paul Corso, St. Louis; Francis J. Clarke, Loyola; Joseph J. Levin, Ohio State; J. W. Brzozowski, St. Louis; W. E. Mishler, St. Louis, and W. F. Sercl, Nebraska.

St. Luke's Hospital—Residents: Louis E. Baron, Tufts College; Ray H. Long, University of Oklahoma; H. J. Theisen, University of Pennsylvania; Kenneth H. Lowe, University of Michigan; M. McKendree Boyer, George Washington University; H. J. Theisen, University of Pennsylvania; Marion F. Stormont, Western Reserve; William H. Woern, University of Arkansas; Robert E. Ballard, Western Reserve, and George P. Vryonis.

Interns: Stanley N. P. De Ville, Western Reserve; Joseph M. Gledhill, Western Reserve; Jack Goldfarb, Ohio State; Samuel Kamellin, Ohio State; G. Norris Miner, University of Buffalo; John Joel Monfort, University of Oklahoma; T. Scott Moore, Jefferson Medical Council; J. Carson Murray, Dalhousie University; Jesse Silsby Parker, Harvard; Robert L. Pohl, Iowa State University; Howard Stephens, Western Reserve; Myron W. Thomas, Ohio State; John A. Topinka, Ohio State; Daniel F. Toth, Western Reserve; Edward L. Vosatka, School of Dentistry, Western Reserve.

Mt. Sinai Hospital—Residents: John C. Drake, Western Reserve; Herman Sampliner, St. Louis; H. Reitman, Western Reserve, and Joseph Gross, Western Reserve.

Interns: M. Dworkin, Rush Medical College; Joseph I. Goodman, Western Reserve; Samuel Lobe, Ohio State; R. R. Maier, Western Reserve; Ben Pilloff, St. Louis; Harold Rand, Western Reserve; Irwin R. Schoen, Cincinnati; R. Strauss, Western Reserve; N. W. Seiznick, Toronto; Jerome Wertheimer, Ohio State.

CLASSIFIED ADVERTISEMENTS

Rates for advertisements under this heading are 50 cents per line, payable in advance. Minimum charge of $1.00 for each insertion. Price covers the cost of remailing answers. Forms close 16th of the month preceding publication.

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—The following have been appointed interns at St. Elizabeth Hospital, Dayton: Dr. William R. Althoff and Dr. George J. Rau, Jr., Dayton; Dr. Louis A. Cropitti, New Orleans; Dr. Edmund F. Ley, Tiffin; Dr. Edward L. Rich, Grand Island, Nebraska; Dr. Lester D. Besecker, Columbus; Dr. Maurice S. Goldberg, Cleveland, and Dr. Robert W. Helms, Convoy. Those recently completing their internships at the hospital are: Drs. W. M. McLin, H. F. Hilty, C. W. Thomas, E. A. Zimmerman, J. M. Owne, A. Kuhr and R. A. Pfarrer.

—Three new appointments to the staff at the Springfield City Hospital have been approved by the board of trustees: Dr. Joseph A. Link, department of orthopedics; Dr. Will Ultes, *X*-ray department, and Dr. Clement L. Jones, electrocardiologist.

—The new radiologist at People's Hospital, Akron, is Dr. Edward L. Voke, formerly radiologist at Memorial Hospital, New York City.

—Members of the medical staff, Bethesda Hospital, Cincinnati, held their annual outing and dinner recently at the Kenwood Country Club. Arrangements were in charge of Dr. Frank D. Phinney, chief of staff, Dr. Charles E. Eha, Dr. C. S. Amidon, and Dr. C. W. Betzner.

—Francis Van Buren has been appointed superintendent of Children's Hospital, Cincinnati. Mr. Van Buren, who for the past few years has been with the Bloomington, Illinois, branch of the Proctor & Gamble Company, succeeds Miss Elizabeth Pierce, resigned, superintendent for the past 10 years.

—Treatment of persons afflicted with jamaica ginger paralysis has cost the Cincinnati General Hospital $221,724.48, according to a report recently made by Dr. A. C. Bachmeyer, superintendent. The first victim was admitted March 8, 1930, and the last patient released about two months ago. The paralysis victims spent an aggregate of 77,911 patient days in the institution.

—R. E. Kepler, formerly acting superintendent of People's Hospital, Akron, has been appointed superintendent of the institution.

—People's Hospital, Akron, has announced a gift from Mr. and Mrs. Stanley H. Austin, Akron, to establish and equip a complete out-patient department. The gift was made in memory of their son who died a year ago.

PUBLIC HEALTH NOTES

—The lowest mortality rate ever recorded for the first four months of any year in Ohio, since the establishment of the Division of Vital Statistics in the Department of Health, was that registered this year. The figure is 12.2 deaths per 1000 living, which may be compared with the next lowest 12.7 for same period of time in 1931. This is 3.7 fewer deaths each day, reflecting 27,782 deaths in 1932 and 28,240 in 1931.

A decrease of 18 per cent was recorded in diseases of the respiratory system, or 597 fewer deaths. Among this group of causes, pneumonia (all forms) decreased 17 per cent or 525 deaths. In diseases of the digestive system, the decrease was 8 per cent. The greatest percentage of decrease in any single cause of death was found in this group, in diarrhea and enteritis under two years of age, a decline of 26 per cent, with 116 deaths in 1931 and only 85 in 1932. A 10 per cent decrease was recorded in deaths due to homicides. Other causes showing decreases were: Influenza, tuberculosis (all forms), diseases of the nervous system, the puerperal state and malformations and diseases peculiar to early infancy.

There was a decrease in deaths among children under one year of age, reflecting 2452 deaths with an infant mortality rate of 69 per 1000 living births in 1931 as compared with 1736 deaths and an infant mortality rate of 56 in 1932. Fewer children were born in 1932, but the ratio of deaths is much less. Every fourteenth child born in 1931 died before its first natal anniversary, whereas in 1932 every eighteenth child will die before its first birthday if the infant mortality rate continues the same throughout the year.

This information shows that although there is a decline in the birth rate, more of the children are living beyond the infant danger age, a larger per cent of mothers' lives are being spared in childbirth, and fewer children are dying from congenital malformations and diseases peculiar to early infancy, which helps to offset the decline in birth rate.

Among the few causes of death recording increases were: Whooping cough, 290 per cent; diphtheria, 103 per cent; diabetes, 21 per cent; accidental falls, 10 per cent; total accidents, 8 per

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cent; cancer, 8 per cent; diseases of the heart, 6 per cent.

—Dr. R. W. DeCrow, for the past eight months connected with the State Department of Health, Division of Communicable Diseases, has been appointed head of the Bureau of Venereal Diseases and Dr. W. P. Johnson, associated with the department for the past nine years, has been named head of the Bureau for Prevention of Blindness.

—Dr. Robert T. Leever, South Charleston, has been appointed health commissioner of Pike County, succeeding the late Dr. O. R. Eylar.

—Dr. Y. Y. Ni and Dr. H. Y. Yao, graduates of Peking Union Medical College and in the United States on a grant by the Chinese government to study rural health activities, have been observing the work of the Lorain County District Health Department.

—Meeting of the Southeastern District, Ohio Federation of Public Health Officials, was held at Gallipolis, June 30. The meeting was presided over by Dr. J. H. Higgins, president of the district, and Dr. F. W. Shane, health commissioner of Gallia County. Addresses were made by Dr. C. E. Holzer, Dr. G. G. Kineon, both of Gallipolis, and Dr. E. R. Shaffer, State Department of Health, Columbus.

—Dr. J. S. Steiner, Bluffton, has been elected president of the Allen County Board of Health.

—Change in the postage rates has caused considerable confusion, as well as additional expense, for the State Department of Health, the chief trouble being the fact that many physicians and others sending in specimens to the State Laboratory have failed to use enough postage, necessitating the payment of postage due by the State Department.

The following article published in the July 15 issue of the Ohio Health News described this situation and contains instructions which should be followed by persons sending specimens to the laboratories:

"Change in the postage rate on first class matter on July 6, especially affecting sealed packages, on which the full letter rate of three (3) cents for each ounce or fraction thereof must be paid, has made much trouble for the departmental Division of Laboratories, and incidentally has cost the Department of Health considerable money. Physicians sending in Laboratory specimens have failed to pay the advanced rate, required under recent Act of Congress, with the result that large payments for postage due have been necessitated thus materially depleting the already scant postage fund.

"In consideration of these facts, and also because deficiency in postage both complicates handling and is likely to delay receipt, the Department is sending out, with every container, a printed "Notice to Senders of First-Class Laboratory Specimens", as follows:

Increase in Federal postal rates on First-Class Matter necessitates the placing of *additional postage on all letters, Laboratory containers* and other sealed packages. The new rate is THREE (3) CENTS for each ounce or fraction thereof!

Failure to attach the proper amount of postage complicates handling in the Postoffice and causes delay in receipt; while the necessity to pay the aggregate large amounts of postage due decimates the Department's already depleted postage fund.

Please exercise care in this matter—and *Expediae Service!*

"Demands for this service are very heavy, and anything which adds to the complexity or expense of handling may cause delay, whereas the utmost possible speed is often of first importance. Health commissioners are urged to impress this fact on their reporting physicians."

—There has been sent to every health commissioner in Ohio a letter in which the State Department of Health admonishes them concerning the futility of swamping the departmental laboratories with water samples from lakes, streams, ponds and artificial pools that are used for swimming. Emphasis is laid on the fact that it is possible at times to secure good samples of water from one part of a swimming pool, which is not being properly treated to keep it sterile, and bad samples, indicating contamination, from another part.



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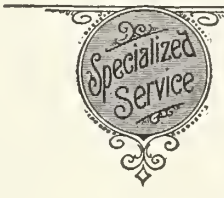
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SEPTEMBER 1, 1932 VOLUME XXVIII Number - - - 9

New Regulations Affecting Physicians, Hospitals and Nurses in WORKMEN'S COMPENSATION CASES, With Comment and Analysis, Pages 659 to 667 of this Issue.

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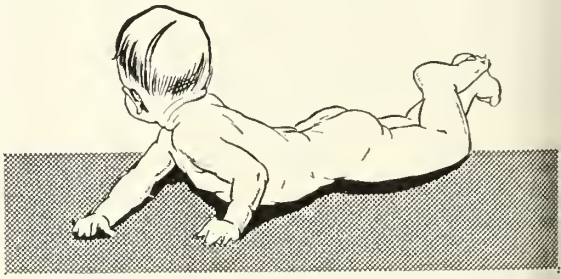
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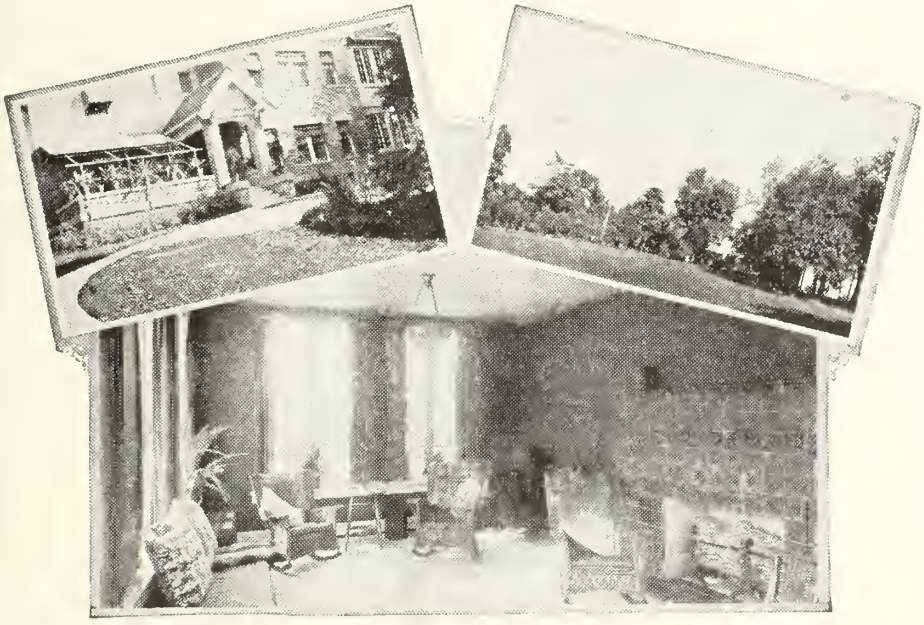
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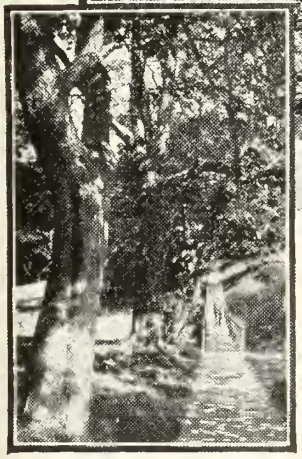
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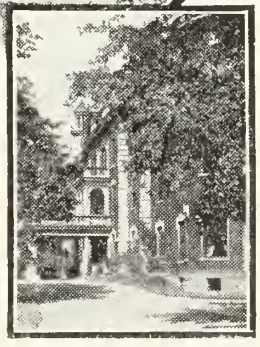
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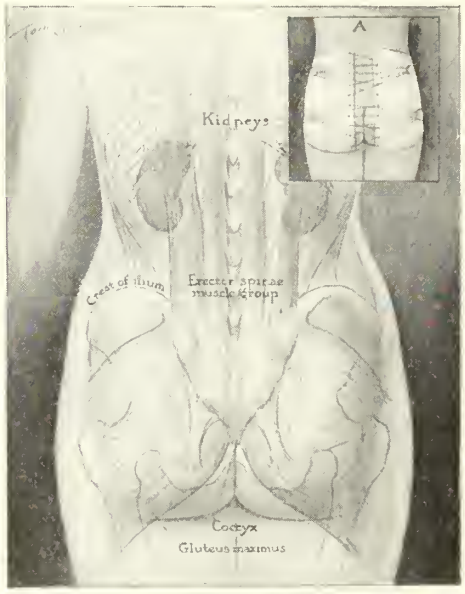
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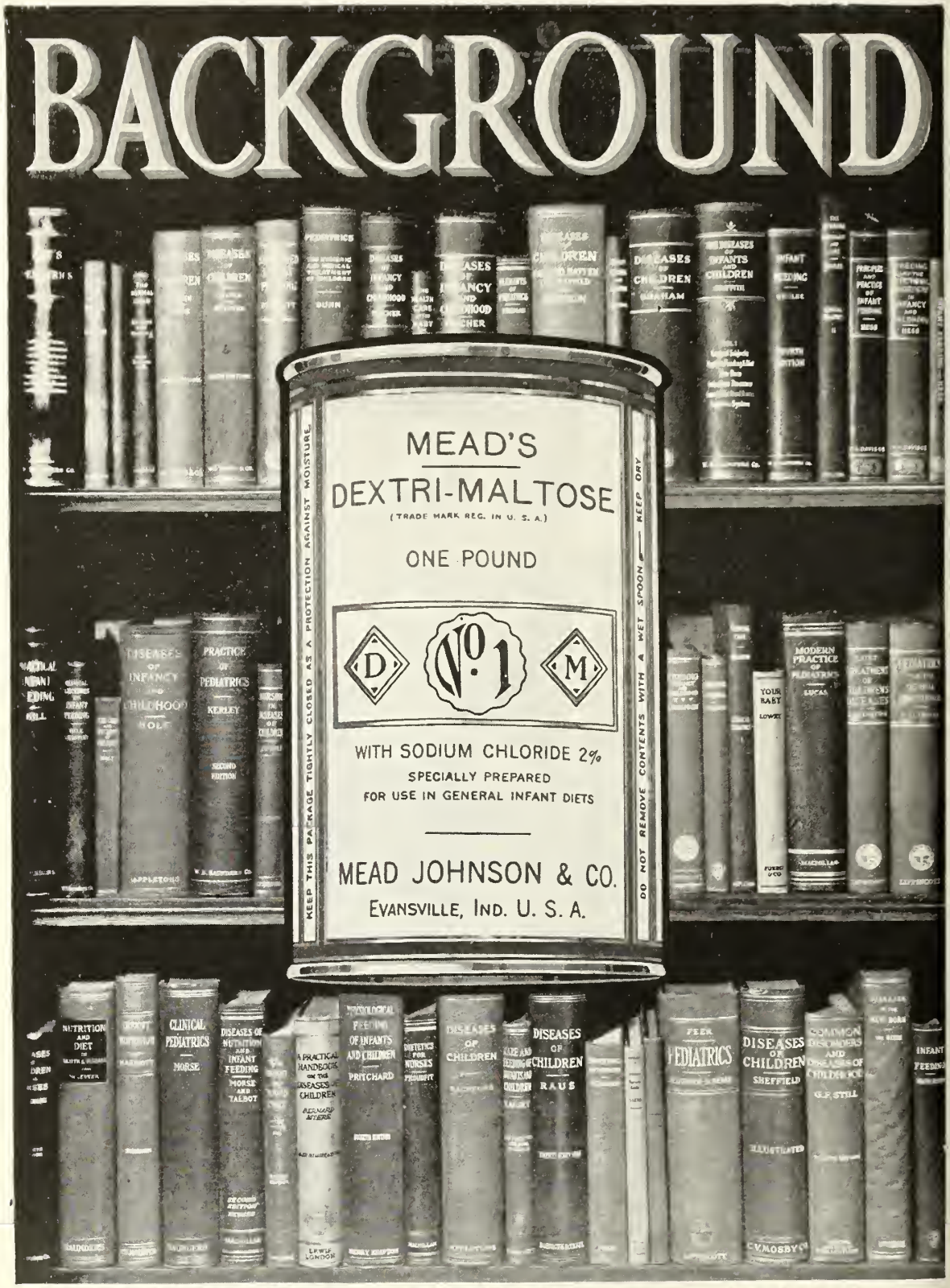
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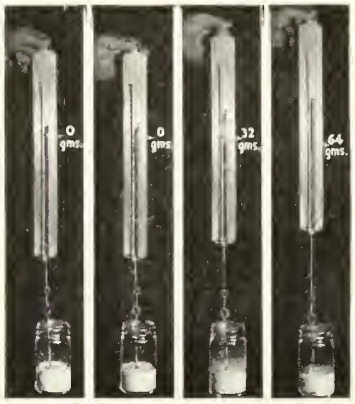
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[1] Marriott: Infant Nutrition, pg. 49.

[2] Talbot: Morse and Talbot, Diseases of Nutrition and Infant feeding, pg. 48.

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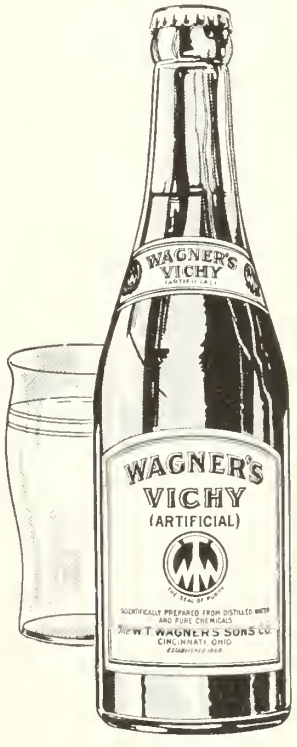
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NEW YORK

PUBLIC HEALTH — SOCIAL WELFARE MEDICAL ECONOMICS and ORGANIZATION PROBLEMS

With Editorial Comment by D.K.M.

Professional and Civic Responsibilities

A. V. Cannon, veteran Cleveland attorney, in a stirring address delivered at the recent annual meeting of the Ohio State Bar Association, warned members of the legal profession that "modern civilization is rapidly reaching a crisis" and admonished his hearers that they must snap out of their lethargy with respect to crucial economic, social and political developments.

"The body politic, like the individual, has been recklessly extravagant," declared Mr. Cannon. "The citizen, busy with his golf, his movies, his bridge game, his thirst for gold, has neglected his civic duty. We boast of our citizenship, but how many of you voted at the last primary? No man is a good citizen who does not belong to some party, who does not assume his responsibilities as a voter, who does not bear his share in community burdens. We are in war, and the lawyer who is not studying the social problems and the economic problems is a shirker and is not doing his duty to the profession, to the state."

The wholesome advice sounded by the Cleveland attorney in his plea for a "militant Bar" on impending questions of vital concern should not be limited to the legal profession.

The medical profession, too, must play the part expected of it in the battle which is being staged for a readjustment of economic, social and governmental matters.

The public has a right to expect the guidance of the medical profession, and other well-informed groups in the professional and business fields, in its search for an answer to many of the perplexing questions confronting it.

The selection at the polls in November of those who will run the machinery of government —local, state and national—for the next few years, is but one phase of the whole question of individual and collective civic responsibility. However, it is one of utmost importance.

Members of the medical profession, like other professional groups and commercial organizations, must assume a considerable portion of the responsibility in seeing to it that the public is properly informed about those seeking public office.

The medical profession may as well recognize the fact that the present is a period of realities. Definite and important questions must be faced and solved, if possible. Many of these are in, or closely related to, government and governmental functions. The solution of those within the scope of government will depend largely on the character and ability of the individuals selected to governmental positions.

Physicians, as citizens and as the best informed group on medical and health matters, should, and have a right to, take a prominent part in all civic affairs, one phase of which is politics in the true meaning of the word. Never before has there been a greater need for strong medical organization and one which is fully aware of its civic duties, one of the most important of which is a concerted, continuous fight for honest, efficient and sound government.

Physicians As Leaders

"There are the few who make things happen, the many more who watch things happen, and the overwhelming majority who have no notion of what happens", according to three classes of the public as divided by Nicholas Murray Butler.

It is the opinion of the editor of *Northwest Medicine* that the medical profession must analyze itself on this basis. That the maintenance of strong medical leadership depends on how well the medical profession, through medical organization, succeeded in minimizing the third group among the profession and in enlarging the first group.

He writes:

"In these times of rapid and radical changes in our educational, economic and social institutions it behooves medical men, as public servants, to measure up to their duties and responsibilities as trained minds. To remain oblivious of these changes leads to stagnation. To be a keen observer of the changing order of things without arriving at some convictions for or against the apparent changes looming on the horizon is not natural to a mind scientifically trained to form conclusions from observed facts. How, then, can we promote more from the second group to that of the first classification?

"A survey of the membership of our medical societies on the basis of the above classification may stimulate ways and means of developing medical leadership from group two and an enlightened support from group three. The most

efficient way to eliminate group three from our medical society membership is to encourage service on some committee activity where one will contact members of the other two groups. To hear the problems of the profession discussed in small groups where thought-provoking plans are submitted cannot help but stimulate thought and interest. When interest is aroused, action soon follows. With the problems of state medicine, contract medicine and group medicine before the medical profession, we cannot afford to permit many members to remain in group three. The more enlightened the county and state medical society membership becomes with regard to the above problems of future medical practice, the surer we will have intelligent leadership capable of formulating policies and practical solutions to these problems which will be worthy of intelligent and cooperative support."

Factors In Health Education

Information to the public on health and medical matters has become an important factor in the general scheme of disseminating information designed to improve society physically and mentally.

Many efforts which have been made during the past few decades to keep the public accurately informed on ways and means of preventing and combatting disease have accomplished inestimable good.

However, like all enterprises conducted on a large-scale, free-for-all basis, and lacking in some instances wise control, health education can be overdone and has its danger points.

There are two primary points to be taken into consideration:

First, what subject should be discussed, and, second, who will do the discussing.

Distribution of information, in written or oral form, on some of the fundamentals of sound community public health activities and on personal preventive medicine can be of much benefit. Public discussions of sanitation problems, how to prevent communicable diseases, personal hygiene, correct living conditions and habits, the value of frequent consultations with the family physician, etc., are important toward keeping society physically fit.

On the other hand, there has arisen a tendency on the part of some interested in the circulation of health and medical information to make their programs too broad and all-inclusive by discussing publicly phases of curative medicine and medical technic, far removed from the fields of sanitation, hygiene and disease prevention.

As a result there has been an alarming tendency on the part of many misinformed individuals to rely on self-medication and to avoid until it is too late the advice and counsel of the qualified medical practitioner. The harm which has resulted from this is quite apparent.

The campaign to get the individual suffering from some physical ailment into the hands of a competent physician as quickly as possible has been retarded to a considerable extent by the public discussion of medical technic, which accomplishes little except to give the public a false reliance on its own ability to cope with disease.

Naturally, health information must be accurate and must be disseminated by those who have the professional standing and ability to command public confidence. The health message of the poorly informed or inadequately trained individual can accomplish much more harm than good.

Furthermore, the dispenser of health information must have a fair understanding of public psychology and mass intelligence. There is a tendency on the part of some engaged in public health education work to write or speak above the heads of their readers or audiences. A large part of the public message clad in scientific and technical language is lost and of no value. On the other hand, there is a tendency on the part of some to assume that the public is entirely void of gray matter, so they simplify their composition to such an extent that it becomes meaningless, as well as ridiculous. This is the tendency, as Heywood Broun puts it, "to go James M. Barrie on the public." It is a difficult job to present, scientific subjects in a popular and, at the same time, accurate form. Few writers and lecturers have the happy faculty of being able to wed these two important factors. That is where health education goes haywire on many occasions.

However, in the final analysis, it is not impossible to make health education of immense public benefit, providing the choice of subjects is confined to those which the public can understand and should know about, and providing the speakers and writers are beyond question and reproach.

The circulation of all kinds of health and medical data indiscriminately and without thought as to what the results may be can hardly be catalogued as health education.

The Practice of Individualism

Dr. William Allen Pusey, writing in a recent issue of *Hygeia*, discusses some of the newer methods and devices proposed for solving the problem of the cost of illness.

Dr. Pusey sees some good in a few of the suggestions for reducing the costs of keeping well and getting well, but in the main he holds no brief for the great majority of the paternalistic and mass-production schemes for standardizing and cheapening health and medical services for the public at large.

His reason for refusing to endorse most of these devices and methods is comprehensive and significant, reasonable, and scientific, and one

which the advocates of impractical schemes will find it impossible to refute.

"The trouble is that most of these schemes of changing practice," Dr. Pusey writes, "ignore fundamental biologic principles, and we can no more ignore them successfully than we can the law of gravitation.

"Nature works individually. Children are an individual product, and men are not standardized to one-thousandth of an inch. Even if they were built according to models for the different years, there is no one who has a supply of parts for the old models.

"The practice of medicine is a highly individualized business. As human organisms we differ much more than we do in shape, and even the custom tailor, who has only the outside to fit, has been able to survive in an age of ready-made clothing; the individual doctor probably has at least as good a chance of survival. Individuals are not simply chemical and physical machines of so much cubic contents and horsepower; they have their own personal equations, their individual nervous and mental make-ups and their particular emotional responses, and these affect fundamentally not only their reactions in health, but much more their reactions in disease. Patients are individual problems. When a man is sick it is not simply a case of pneumonia, it is John Smith with pneumonia. That is one reason the individual doctor has been able to hold his own throughout all these years.

"As a matter of fact, the private physician is not an expensive commodity, not as expensive a commodity individually as he is entitled to be; but, expensive or cheap, he is a necessity to the man who wants to get the best that he can buy with his money. And it would, in my opinion, be a wiser social movement to try to make his profession more attractive, so that he will be just as good a doctor as opportunity can make him, rather than to try to make him cheaper."

Whether the public will be swayed by the forces of emotionalism or be won by logical and scientific arguments such as those here presented, depends to some degree on the conduct of the individual physician and on his ability and skill to individualize each case, realizing that it is the patient as well as the disease who is being treated.

Photographic Advertising by Physicians

Problems confronting the medical profession and medical organization, be they social, economic, or whatnot, are more or less universal.

Naturally, some specific questions exceedingly acute in Ohio may not necessarily be of so great import in some neighboring state, due to varying local conditions.

However, human nature does not vary to any considerable extent from coast to coast, so most of the problems confronting the profession of Ohio are of equal importance to the physicians of any of the other states, and vice versa.

For that reason the comments, opinions and policies of medical organization in states other than Ohio should be of interest and importance to members of the Ohio medical profession, since they represent the attitude of physicians generally on mutual questions.

The following comment appearing in a recent issue of *Colorado Medicine* undoubtedly will be of interest to Ohio physicians since the question discussed is one which has been a disturbing factor in various parts of this state during the past few years and one which involves an ethical problem of far-reaching effect:

To quote:

"At the request of the Colorado State Board of Medical Examiners and with the approval of the Board of Censors of the Medical Society of the City and County of Denver and the Committee on Public Policy of the Colorado State Medical Society, the following suggestions are published editorially.

"A large newspaper publishes, about once a year, a 'Greater Denver' edition. This includes many pages of photographs of supposedly prominent citizens, with their names and occupations. Each person whose photograph is thus published agrees to pay a certain sum of money to the newspaper. Candidates are supposedly singled out and 'invited' to permit such publicity, in the name of civic benefit, but no less than one hundred Denver physicians were importuned for the recent special edition. It is obvious that the newspaper was less solicitous of a candidate's eminence than of his willingness to pay a definite, and not inconsiderable, sum of money.

"Any payment made by a professional man to secure publication of his photograph places such publication within the category of advertising. The medical and legal professions interpret this as an impropriety, even though the payment is allegedly for the sole purpose of retiring the cost of publication.

"Such a captioned photograph does not constitute a professional card, and if paid for either directly or indirectly it becomes a solicitation of business by advertising, hence a breach of professional ethics. An advertisement is distinguished from a news item in that the former is paid for, directly or indirectly. The amount or form of payment, or what item of cost it is supposed to cover is immaterial.

"The Denver Bar Association, through its official publication, *Dicta*, has reprimanded those of its members who subscribed to the recent newspaper edition, a special committee of the association having interpreted the code of legal ethics to show that such publication of photographs constituted unethical advertising.

"The Board of Medical Examiners, the Public Policy and Publication Committees of our State Medical Society, and the Board of Censors of the Denver Medical Society, feel that such publicity is equally contrary to medical ethics, and also feel that action corresponding to that of the Bar Association is in order in our own ranks.

"It is to be hoped that drastic action in such directions will not be necessary, that, instead,

each physician will be ready with a resolute "No" when approached in the future on such publicity projects."

Energy and Effort Plus Mature Judgment

Dr. Edward O. Gertenbach, Milwaukee, writing in the *Milwaukee Medical Times*, issues a challenge to the younger generation of physicians to take a more active interest and part in organized efforts to solve some of the pressing problems confronting the medical profession.

Dr. Gertenbach believes that too many physicians in the past have been indifferent to social and economic trends affecting the practice of medicine and that they are to some extent responsible for some of the confusion which exists today in the medical field.

Undoubtedly, Dr. Gertenbach is partially correct in his observation. True, many physicians have ignored social and economic trends. On the other hand, there are many who have for years been warning the profession that it must awaken and take an active part in those things which are not primarily scientific aspects of medicine.

However, his advice to the present and oncoming generation of physicians merits careful consideration.

"Because they," Dr. Gertenbach declared in referring to the physicians of past generations, "were indifferent to the trend of the times, when it was within their power to change it, do we intend to sit back and adopt the same attitude or are we willing to tackle the problem of today?

"It seems to me that we of the younger generation should have as much to do with the solution of present day problems as they,—yes, perhaps even more,—for any policies now adopted will prove themselves either feasible or not during our lifetime.

"We are anxious to do our bit, but sit back and wait for the opportunity to present itself, whereas it is constantly before us. Without concerted effort, without cooperation among ourselves, we will let things shape themselves just as they have until suddenly we awaken to find that our field of medicine has been taken from us to be usurped by someone with no knowledge of medicine.

"Are we going to exert an influence in an adjustment of medical problems? Certainly not as individuals,—because our voices will be drowned out by others. Even younger medical men are more serious and more conservative than men in other fields, and the trying period which we are going through makes us still more level-headed. Collectively we can make ourselves heard.

"Utopianism is not one of our attributes and no one of us can suggest a remedy for the ills in our field, but by study and suggestions as well as being constantly alert to subtle changes we can arrive nearer to a satisfactory solution."

How many Ohio physicians who have been out of medical school but a few years are doing some of the things to which Dr. Gertenbach refers? How many county medical societies are giving its younger members an opportunity to take an active part in its organized activities and are willing to give serious consideration to the suggestions and opinions expressed by some of the younger men?

The future of medicine and medical organization rests on the shoulders of the young physicians. How well they will carry on depends largely on the inspiration and opportunities given them now.

Organized activites builded upon the experience and mature judgment of the veterans of medicine and the energy and aspirations of the younger practitioners will play a vital part in the preservation of the ideals of medicine and in solving many of the present-day problems.

Continuous Self Instruction

Not long ago Dr. Benjamin F. Lyle, Cincinnati, whose grandfather and father were physicians, whose two sons and one daughter are physicians, and who had two uncles and two cousins who were physicians, celebrated the 50th anniversary of his entrance into the practice of medicine.

Commenting on some of the changes which have taken place in medicine during the span of four generations represented by his immediate family, Dr. Lyle made this pertinent observation:

"Graduation from medical college is literally only a 'commencement' in the profession. There is never a time when a physician can sit back and say to himself, 'Now I know medicine'. He must read all the latest medical papers and spend a large part of his time keeping up with the medical world, or his diploma will mean nothing."

Dr. Lyle's sound advice to the younger men in the profession who, perhaps, have not as yet realized the importance of continuous effort to improve their knowledge of medical matters, is of the same tenor as the following paragraph from an editorial squib published recently in *The Bulletin of the Wayne County (Detroit) Medical Society:*

"Success in medicine is not built on one brilliant stroke. It is the result of sustained effort. This is true also in great part of all professions. Leadership is secured and maintained by work of a high standard over a long period. When the standard falls, a new leader steps into line. Single strokes do much to win a place in the sun. Repeated strokes are essential to keep it."

These observations by men who have learned from experience denote the line of distinction between the successful and the unsuccessful physician.

The Nature of Cancer

B. S. Kline, M.D., Cleveland, Ohio

A CANCER is an abnormally organized epithelial tissue which usually grows at a greater rate and to a much greater extent than the normal tissue from which it develops. There is good evidence that the malignant transformation depends, as Hauser[1] maintained, upon a fundamental change in the biological characters of the cell. According to von Hansemann[2] and Boveri,[3] the cancer cell is an epithelial cell that has undergone an irreparable change involving its chromosome complex owing to atypical mitosis. The majority of its descendants, however, receive the same new complex by regular mitosis.

Cellular abnormalities, including cancerous transformation, are brought about by certain physical, chemical or biological agents acting directly upon the cells, upon their local environment, or upon both. In most instances, a state of chronic irritation is imposed upon the tissues and certain isolated cells instead of undergoing atrophy and death as do most, persist in the altered environment. Subsequently the isolated cells undergo progressive abnormal changes apparently of precancerous nature. Later, because the characteristic structure of a cancer cell is not clearly discernible through the microscope, the pre-cancerous cells may be indistinguishable from truly malignant ones.

Once fully developed, the cancer cells reproduce cancer cells. As pointed out by Blair Bell,[4] cancer cells are characterized by as avid a responsiveness to the chemotaxis of nutriment as is the trophoblast. Like the trophoblast, cancer cells possess an unusual capacity of establishing connection with a regional blood supply. Growing rapidly through the tissues, the new cells surround and penetrate the blood vessels and the lymphatics. Small masses of cancer cells becoming detached in the vessels are transported to local or distant organs. In the metastatic foci the cancer cells, just as in the primary site, grow rapidly through the tissues and readily establish a connection with the blood supply. By interfering with various organ functions, by their degeneration products, by causing hemorrhage and by undergoing secondary infection the cancerous growths cause anemia, emaciation, loss of strength and finally the death of the individual.

The factors relating to the pathogenesis of cancer are given in considerable detail in standard text books,[5,6,7] The significant ones may be presented as follows:

1. Nutriment

Body cells grow not merely in their normal locations and attachments but also in many other locations as shown by the occurrence of various ectopic congenital tissue rests, by the numerous successful implantations at different sites of various differentiated tissues, gland transplantations and the growth of endometrial tissue in the skin following Caesarian section for instance. Most striking is the growth of animal cells in cultures outside of the body. When the environmental conditions including nutritive substances are adequate, such cells live, and reproduce themselves. (Carrel's[8] nineteen year old culture of fibroblasts still resembles the fibroblasts in the original tissue explant). According to Carrel "the malignant types," of cells "which differ from one another in some aspects, have certain properties in common. They digest fibrin and feed upon substances or tissues which are not utilized to the same extent by normal cells. We may assume that in vivo they are malignant because they have the power of manufacturing from the neighboring tissues or interstitial lymph the nutrient substances which promote their unlimited proliferation. An important fact is thus brought to light —the mutability of certain types. Malignant cells are variants of the normal type. They differ slightly from it in some of their properties. These differences are not qualitative, but only quantitative. They are persistent. The cells do not revert to the original type even after years of cultivation in vitro. They are fixed variants, possibly analogous to those arising in microbic dissociation under the influence of several chemical substances and of the lytic principle of Twort."

2. Variability of Cells

According to Boveri, all differentiation of cells is due to certain alterations in one or more chromosomes. Accordingly, metaplastic changes such as the change of columnar cervical or uterine epithelium to stratified squamous type follow certain alterations of the chromosome complex of the affected cells. The change to a malignant tumor cell then may follow the direct specific action on certain chromosomes of such agents as X-rays, radium, tar, toxins, mutagens (Murphy[9]) and viruses but more frequently follows after the chronic irritation of tissues by the agents mentioned and by others such as the friction of rubbing, heat, aniline, paraffin, bacteria and animal parasites. According to von Hansemann, the cells undergoing certain atypical mitoses, suffer a regression in differentiation and acquire a greater capacity for multiplication. Elaborating von Hansemann's idea of anaplasia, Boveri maintained that a state of chronic irritation gives rise to a great increase in cells and favors abnormalities in cellular division. A sup-

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pression of cell division after the division of the centrosome and the nucleus followed by a tetrapolar mitosis, he claimed, may result in a malignant tumor cell. This cell, however, transmits its characteristic properties by normal bipolar mitosis and multiple such reproductions constitute the cancer.

3. HEREDITY

The evidence in regard to this factor favors the assumption that susceptibility to cancer is transmitted in individuals and not the elements of the tumor itself. Furthermore the fact that cancer may be produced by tarring the rabbit's ear whereas similar tumors rarely if ever occur spontaneously in this location shows that even with no demonstrable hereditary susceptibility to cancer, a tissue may possess the capacity of malignant transformation following the action upon it of certain agents.

4. ISOLATION OF CELLS

This factor emphasized by Cohnheim,[10] Waldeyer[11] and Ribbert[12] results either from disturbances in embyronal development (e.g., adrenal rest in adrenal. Adrenal rest in kidney), postnatal involutionary processes (e.g., isolation of glands in appendix, breast, pancreas, etc.), hormonal influences (e.g., isolation of acini in thyroid following repeated hyperplasia and involution), trauma (e.g., implantation of endometrium into myometrium by curettage) and most commonly following chronic inflammation of tissues (e.g., cirrhosis of the liver, chronic inflammation of the lung, kidney, etc.)

The more or less complete isolation of cells or cell units of a lobule from nerves and proper lymphatic drainage undoubtedly plays a role in tumor formation. Whereas normal metaplastic cells differ greatly from the cells they replace, benign tumor cells and even certain malignant tumor cells apparently differ but little from the original cells of the part. The benign tumor certainly is characterized more by the type and extent of its growth than by discernible difference of its cells from normal cells. Certain benign growths in the breast, for instance, show pictures suggesting gradual isolation from the remainder of the lobule of certain glandular units by increased proliferation of regional stroma. The subsequent reproduction of these units in roughly spherical masses many times the size of the normal lobule, constitutes the benign adenofibroma. Even more striking are the appearances in the thyroid. Here, not infrequently, groups of acini are observed without associated nerves and lymphatic vessels, isolated from the remainder of the lobules. Transitions from this picture to that characteristic of adenoma (apparently following repeated stimuli to growth and involution) support the definition of a benign tumor given below. Whether the benign tumor is composed of but one type of cell as is the fibroma, for instance, or of many types as is the endometriofibromyoma of the uterus, the neoplasm is apparently the growth of the cells or cell units of normal or nearly normal tissue in abnormal organization and to an abnormal extent after complete isolation from coordinating lobular structures.

To continue, certain cells becoming isolated during the involution of the appendix and certain structures in small cortical renal scars, for instance, may undergo moderate changes that may very well be of anaplastic nature. Stimulated to proliferation after complete isolation and moderate anaplastic change, the altered cells extend through the regional tissue much like a carcinoma but do not metastasize. The abnormal organization, the absence of coordinating lobular structures, and the abnormal extent of these growths of modified cells and cell structures are the characteristics of the carcinoid.

Of greatest significance are the precancerous and cancerous changes occurring in epithelial cells. These usually involve cells isolated in tissues exposed to abnormal involution or chronic irritation but presumably may take place in normally organized tissue by direct action of certain specific agents. Ordinarily the cells concerned apparently first show various abnormalities of a precancerous nature and then by further changes, frequently indeterminable they become fully developed cancer cells. Much more discernible than the cellular changes are the changes involving the cell structures. Glandular tissue, for instance, may come to have an alveolar as well as a tubular appearance. It may appear as solid narrow cell nests, or as narrow epithelial strands surrounded by abundant stroma. Just as benign tumors repeatedly reproduce the cells or cell structures as they appear when first completely dissociated from coordinating lobular influences, so cancerous growths reproduce the cells or cell units as they appear when the malignant changes are first fully developed. It is of the greatest importance to classify tumors on the basis of the units composing them and to determine their origin since ordinarily the more the unit differs from the normal, the greater the malignancy. In addition to glandular carcinomata composed of units apparently differing but little from normal and others of atypical units described above, there are certain rapidly fatal medullary and even solitary cell carcinomata conceivably derived from extremely anaplastic glandular structures.

The markedly greater variation from normal of tissue units composing many malignant tumors as compared to those of benign tumors suggests the importance of changes in the cells prior to their complete isolation from coordinating lobular influences. It may be that if such changes are minimal, a benign tumor results, and if severe and of anaplastic nature the tumor is malignant. A benign tumor in this sense indicates that the prompt isolation of its original cells from co-

ordinating lobular influences may in reality prevent the formation of a malignant tumor. Furthermore, whereas benign and malignant tumors grow without lobule formation the benign tumors apparently depend entirely for their abnormal organization upon complete isolation from coordinating lobular influences, whereas the malignant tumor grows in abnormal fashion for the same reason and because of the great capacity of its cells to grow diffusely through tissues.

Whereas the type and extent of benign tumor growth may be dependent in great measure upon factors other than the character of the tumor cells, such is not the case with malignant tumors. Here, a study of early primary and early secondary growths reveals their avid responsiveness to the chemotaxis of nutriment and their unusual capacity of establishing themselves about the blood vessels. Growing rapidly through the tissues, the cancer cells surround and penetrate the blood vessels and the lymphatics. As is well known, small masses of cancer cells become detached in the lymph or blood stream, are transported to local or distant organs, grow rapidly in the metastatic foci and readily establish a connection with blood vessels. By invading and replacing body tissues they interfere with various organ functions and further by their degeneration products, by causing hemorrhage and by becoming secondarily infected the cancerous growths cause anemia, emaciation, loss of strength and finally the death of the individual.

Benign tumor cells in parenchymatous tissues may undergo anaplastic changes just as normal cells may but in general this occurs infrequently. On the other hand, benign tumors projecting beyond a lining surface as for instance, adenomata or polyps of the intestine are quite definitely more prone to malignant change than is the normal intestinal mucosa. Furthermore, cells may first undergo metaplastic change and then anaplastic change as for instance, when the columnar epithelium of the prostate undergoes metaplasia to a stratified squamous type and these cells following severe anaplastic change eventuate in a cancer composed of stratified squamous cell units atypical for the organ. It can readily be appreciated that difficulties exist in determining the origin and the degree of potential malignancy of cancers composed of units showing marked anaplastic or metaplastic and anaplastic changes.

Whereas malignant tumors generally progress rapidly in primary and in metastatic foci, there are certain ones which become more or less stabilized or even regress. Regression may be due (a) to vascular disturbances with necrosis of tumor tissue, (b) to proliferation of regional connective tissue with progressive atrophy of the tumor cells, or (c) to the occurrence of abnormal mitoses with defective cell formation in the tumor tissue. Cancer cells may be destroyed by various agents lethal to normal cells and are apparently less resistant to *X*-rays and radium than are normal cells.

Experience with tissue diagnosis has made it discouragingly clear that with our present methods of microscopic examination limited to a magnification of only a few thousand times, little hope for a solution of the problems of diagnosis and prognosis of cancer can be entertained. Whereas the microscope has made possible innumerable amazing cytological revelations permitting one to say, for instance, that 2,000,000 ova each made to make a man may make less than a teaspoonful, and that 200,000,000 spermatozoa are sent so that one male cell shall assist an ovum in the stupendous task of making a man's weight at maturity 30,000,000,000 times what it was at his start in life, it has not revealed the distinctive structure of the ovum of man nor has it revealed the characteristic structure of that more rapacious individual, the cancer cell.

Additional knowledge of the cancer cell will come probably, not by improvement in stains but by the development of a method utilizing the principles of the Rife[13] super-microscope or of *X*-ray scattering as proposed by Clark, Bucher and Lorenz[14] or by some other principle permitting an examination of the tissues at a magnification of 20,000 to 100,000 times. Perhaps the tumor diagnostician of the next generation will completely ignore such crude and uncertain criteria of malignancy as abnormal organization, abnormal extent of growth, evidence of invasion, hyperchromatism of nuclei and atypical mitoses that are employed today. Equipped with the proper apparatus, he may plot the cytological map of nuclei and noting certain genic patterns call the single cells, including those of cancers, by their proper names.

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DISCUSSION

MONT R. REID, M.D., Cincinnati: It has been most interesting and instructive to hear Doctor Kline's discussion of this very plausible origin and nature of cancer cells. What he has said is not only logical but can be supported in large measure by a great many clinical observations. It is at least a relief to hear a discussion of this subject without injecting into it the theory of the infectious etiology of cancer. Many factors such as irritation, instability of tissues and possibly infections may play a role in the development of the abnormal mitotic changes which eventually result in the autonomous cancer cell, but, after this, the cells certainly grow and disseminate under laws of their own regardless of the factors which may have played a role in the initiation of the first cancer cell. They certainly become fixed variants, as pointed out by Doctor Kline, no longer controlled by the normal influences that determine tissue growth in the body.

The actual production of a cancer cell by suppression of cell division after division of the centrosome and nucleus followed by a tetrapolar division of this cell is an extremely interesting theory, although it does not take into consideration the etiologic factors responsible for this abnormality. The evidence that this abnormality of the cell results most frequently where physiological processes or irritative lesions necessitate tissue changes and repair over a long period of time is certainly well established. Two striking examples of the effects of physiological processes are the high incidence of carcinoma of the breast and uterus—two organs which are constantly in a state of wide fluctuations of function and tissue changes almost throughout life. Chronic irritative lesions likewise cause tissue changes and a persistent and abnormal activity on the part of the body to repair damage. Doctor Kline has pointed out to you cellular abnormalities, other than the cancer cell, which may result—such as precancerous cells, metaplasia of tissues, etc. The high incidence of squamous cell carcinoma of the lung and sinuses for example, is proof of the metaplastic changes that occur in the columnar mucosa before the appearance of the fully developed autonomous cancer cells.

The influence of nutriment upon the growth of cancer is strikingly illustrated by the behavior of cancer in young and old people. Everyone knows of the rapidity of growth of cancer in young people; the frequent slow growth in old people, and as pointed out by Kline, the occasional regression of a cancer apparently due to a lack of nourishment.

The remarks of the speaker concerning benign tumors and the similarity of their cells to normal tissue cells are especially interesting to me. All of you are familiar with the great discussion and confusion caused by the argument as to whether adenomas of the thyroid are tumors or localized areas of hyperplasia. If it would help to clarify the situation I personally would not have any objection to regarding all benign tumors as localized areas of hyperplasia. It seems to me that the argument is inconsequential.

The cancer cell, however, is entirely different; the degree of its histological variation from the normal is a fair index of its malignancy.

The ability of the body to kill cancer cells which are injected into the blood and lymphatic streams always raises the question as to the percentage of viability of cells that get into these streams from the primary growth. The actual fight that the body puts up against the development of cancer would be interesting to know. For every cancer cell that gets a hold, grows, disseminates and kills how many may previously have been destroyed by the body? The occurrence of cancer in families seems to indicate a certain variability of the body in this respect.

I am particularly pleased with Doctor Kline's prediction that greater magnification and consequently a better knowledge of cell structures will add materially to our understanding of cancer. His paper has been most instructive.

Has the Treatment of Diabetes Mellitus Become Too Technical?

LOUIS G. HEYN, M.D., Cincinnati, Ohio

THE problems of diabetic therapy are becoming increasingly complicated. This applies not alone to the medical treatment, but to the social aspect of the disease as well. With an estimated incidence in the United States of more than 1,000,000 cases, we are confronted with the problem whether or not diabetes mellitus must ultimately be considered as a mass or community affair and, like tuberculosis, be linked with a general public health problem. If this be attempted with the formation of diabetic hospitals, dispensaries, diet kitchens and a visiting nurses' program, it will tax an already burdened public welfare organization. Perhaps such an arrangement would be desirable from a scientific standpoint and as a social experiment, but is such a solution necessary? I venture to state, that until socialized medicine becomes a fact, and that is still quite remote, we must accept the other alternative and be willing to remain individualistic in handling diabetic patients; and if the latter be the case, we practitioners of medicine must learn to treat diabetes more effectively. I do not say this disparagingly or in criticism.

The present status of diabetic therapy has developed through a natural process of evolution and has arrived at the present state of development by very interesting stages. The history of the dietetic management of the disease would fill many volumes and no doubt the future will continue to add to that literature. When we recall the names of Cantonia, Bouchardat, Naunyn, Kolisch, Magnus Levy, Minkowski, VonNoorden, Guelpa, Allen, Joslin, Newburgh, Wilder, Wood-

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yatt, John, Geyelin, Rabinowitch and many others, each name recalls a brilliant work of the last half century or more, which was crowned by the announcement of insulin by Banting and Best. As we recall the names of these men, however, we are also reminded that almost everyone of these keen observers has offered to us a somewhat different method of arranging our diabetic dietary. We are baffled by the number of methods offered, an embarrassment of choice. Each observer has been successful in his method, but are we not reminded of the number of cures for eczema? Any one of the methods will often suffice. A certain number of times none will succeed. What method offers us the best solution? This question has come to me often during the past ten years as no doubt it has occurred to many of you, and I have seen among medical students the confusion which has attended their attempts to fathom the various formulas offered the diabetic. For those of us who have treated the diabetic in the hospital, how simple has it been to send our orders to the diet kitchen, formulas 1, 2, 3, 4, and treat our cases by rule of thumb, be they old or young, 100 pounds in weight or twice that amount. When the patient leaves the hospital (or if he has had no hospital residence at all), everything is changed. The patient must now again enter the struggle for a livelihood, eating one or two meals a day away from home; his caloric requirement has changed. Social adjustment must be made or he possibly develops some secondary illness. We are taxed for a solution, and possibly in our despair we cast the burden from us and send our patient to the specialist. Must this be the solution? I trust not. The man in general practice must not fail in this crisis.

Now if I may rehearse briefly the dietetic regimens offered since Naunyn, we note that this pioneer and his successor, Von Noorden, had a diversified dietary consisting of days when protein was limited between 100 and 150 grams and carbohydrates were restricted, while fats were not restricted. This diet, termed strict, was a test diet to which 50 to 100 grams of bread or its equivalent might be added whenever tolerance was to be determined. When carbohydrate tolerance was low, and perhaps the patient did not become sugar free upon the strict diet, he was placed for a day or two upon a low protein diet, which might contain fish or eggs, but mostly vegetables. If this proved not successful in sugar elimination, one or two starvation days were added and then perhaps again vegetable days and possibly an oatmeal day especially if acetone bodies became excessive. Alcohol was also used as antiketogenic preparation. When the patient became sugar free as usually happened on starvation days, the diet was built up gradually by the addition of protein, then carbohydrates, with vegetable days usually interspersed.

I was a volunteer in the Von Noorden Clinic 20 years ago, and witnessed the splendid results of his diet in his wards as well as among his private patients in the Cottage Sanatorium, who had traveled to this master from all parts of the world. Von Noorden had his low protein days, his starvation days, and his oatmeal days suggesting the high carbohydrate diets of our newest idea in therapy today. He had his failures also, and often spoke of the time when a hormone might be found. Now that insulin has arrived he contends that he uses it infrequently!

Guelpa, in France, and almost simultaneously Allen in this country after brilliant animal experimentation stressed the importance of strict under nutrition, and their diet formulas restricted all food elements, carbohydrates, proteins and fats. Their results with sugar elimination were excellent, as might be supposed, and the method was hailed as a brilliant achievement. Prominent medical men acclaimed the method as a cure. The treatment, however, was incompatible with health and happiness or the pursuit of a livelihood and Allen's treatment per se has been deserted. His contentions, however, have not been lost sight of. Newburgh and Marsh found that they could add fat to these undernutrition formulas and accomplish the objective in a better fashion for the patient. They kept down the protein content to what they believed to be a maintenance quantity, 2/3 gram per kilo of body weight and sacrificed carbohydrates to fats. Newburgh's diet formulas in printed form for the world to use were well conceived and served a fine purpose for several years. Dietetic nurses were well trained in his formulas and they worked out especially well in hospital wards.

During the latter part of the world war, it became necessary in Germany to put diabetics into active service. In spite of the great physical and emotional strain, these diabetics improved, and the lesson learned by this experience was that undernutrition and especially low protein regimen was responsible for the miraculous improvement in these diabetics.

I believe that many patients object to the large amounts of fat in their diet as there will always be patients who object to large amount of vegetables in some diets, and many digestions will not tolerate increased bulk and roughage. Wilder and Woodyatt took exception to a very high fat content as tending to promote ketogenesis and they proposed a fat glucose ratio approaching approximately 1½ to 1 instead of Newburgh's 2½ or 3 to 1. The present more recent modification will still further reduce the fat and at the same time increase the carbohydrate content. As paradoxical as it might seem, the carbohydrates in some of the formulas today are so abundant that patients have objected to the quantity of them given. The sponsors to these newest innovations of high carbohydrate, low fat and undernutrition are notably Geyelin, in this country,

Rabinowitch in Montreal and Adlersdorfer in Vienna. Joslin attempts to give every patient at least 100 grams of carbohydrates, and advocates of the low fat regimen claim the reduction of cholesterol in the blood with its possible deleterious effect upon the blood vessels. Wilder who provides his patients with 80 per cent of the calories in fats has seen no development of arteriosclerosis or tuberculosis in the children treated for many years. It is, no doubt, true that high fats are less comfortable to many, while high carbohydrates make the regulation of sugar output more difficult. Perhaps a lower fat promotes better glycogen storage and high carbohydrate possibly increased pancreatic stimulation. One unit of insulin is said to take care of two grams of carbohydrate in better fashion than one gram of fat. Diets rich in carbohydrates are especially valuable with milk, vegetables and fruits predominating, and with insulin when kidney and heart complications are present.

Joslin's chart illustrating the change in diets during the past 17 years is illuminating. His carbohydrates have increased from 26 grams in 1915 to 144 grams in 1931 with an average 21 units of insulin to take care of the increase. The protein content has changed from 76 grams to 90 grams after attaining a high level of 123 grams during the transition period.

Again, if we take a typical Joslin 3 diet, we find about 60 grams each of protein and carbohydrate and 150 grams of fat with 1770 calories while a Newburgh 3 diet of 1826 calories contains 34 grams of protein, 29 grams carbohydrate and 173 grams of fat.

Rabinowitch's diets have averaged an increase of carbohydrates from 89 to 246 grams without an average insulin change—with calories reduced from 1906 to 1774, by means of fat reduction with a cholesterol decrease from 0.220 to 0.184.

And so we continue ad finitum upon the variations which have been offered in the diabetic regimen (and in so doing, the solution does not become easier). I am convinced after rehearsing the story of the dietetic management of diabetes mellitus that the pendulum has swung forward and back again arriving at the point where a solution might be (simplified) and summed up in the following: A protein content of 1 gram per kilogram of body weight, a fat content diminishing with a carbohydrate rise and vice versa, with a caloric requirement of 25 to 35 calories per kilogram depending upon the body activity and a maintenance of weight, not overweight. But I also contend that we can not insist upon mathematical accuracy in prescribing diabetic diets.

Patients live in homes and not in calorimeters. The human body does not permit of perfect accuracy in dietetic quantities any more than it will do in estimating dosage of medicine. There is a certain variable, and it is likewise true that quantitative accuracy is also very difficult in food values. When we consider the differences of carbohydrate content in vegetables at different seasons of the year or the difference in the fat content of a piece of meat or the size of an egg or the value in a piece of bacon, whether it be well cooked or medium, a variability estimated at as much as 25 per cent, we may judge how difficult scientific accuracy may become even in hospital treatment, and much more so in the home.

Again in dealing with a patient with a more rapid and perfect digestion as opposed to one whose digestion may be retarded, blood sugars may easily vary at different times of the day. In the *Deutsches Archives for Kluin Medizin, January, 1932,* A. Althanasione writes upon the biological values of the carbohydrate content of fruit and vegetables in the nourishment of diabetes. He shows that many foods with the same carbohydrate content show wide variation in the available carbohydrate and this variation is still greater in ill persons than in healthy subjects. These points he proves in a series of blood sugar estimations. For instance, he shows that in two blood sugar curves with apple and peaches with a like amount of carbohydrate content, the peach curve rose from 130 mg. to 230 mg. and fell to 170 in four hours, while the apple curve rose only to 190 mg. and fell to 110 mg. in four hours. These differences prevailed all through the fruit, vegetable and nut varieties of food, while such articles as bread and cereal, where there was more or less easily digestible absorbable starch content, a more uniform sugar curve was obtained.

In citing these variations and with the assertions that quantitative food values can not be made with complete accuracy, I would not have you believe that I am preaching laxity in dietetic restriction, but I dare to hope for a simplified solution to this problem in biologic mathematics where one factor the patient is a variable and uncertain quantity, and where quantitative food values may also vary. I, myself, am somewhat fearful in offering a possible solution to the problems which I have presented to you, but perhaps out of such discussions as these, we may arrive closer to such a solution. I would omit from this discussion the milder cases of diabetes, where only a slight restriction of carbohydrates may suffice, and also the severest cases including those in children, where insulin is necessary and the dietetic formulas may readily be modified according to insulin dosage. The treatment of diabetic coma also has become more or less a stereotyped procedure and need not be dealt with here.

The vast majority of cases lie between these two extremities. The consideration of these cases must include the social condition of the patient, his intelligence and his general physical state. I would like to assume that the physician is sitting opposite to his diabetic patient in his office. He has explained to him the principles underlying his cure. There is then a consideration of food

values in general, and each subsequent visit might be in part a discussion of these values so that the visit could be made into an interesting lecture in dietetics. The interest in the visit would thus be augmented and the physician also enjoy the role of teacher. The patient is taught also to examine the urine for sugar and acetone.

Now in a general way I would like to arrange the diabetic diet as follows: A fair portion of meat, fish or fowl weighing four to six ounces depending upon the patient. This would comprise approximately one half the protein requirement, also one egg; two tablespoonfuls of cottage cheese or a glass of milk would make up the remainder protein, except that present in smaller amounts in almost all food substance. The fat of meat, two or three slices of bacon, one and a half to two ounces butter, four to six ounces of 20 per cent cream and perhaps some fat in the salad dressing can easily constitute a fat content of approximately 150 grams. The daily carbohydrates can first be reckoned with 5 per cent and 10 per cent vegetables measured say in three tablespoonfuls or one-half cupfuls to constitute five to ten grams of carbohydrates each. Then fruits, as half a grapefruit, orange, apple or a small cup of strawberries would add another 10 grams of carbohydrates. Bread is a luxury and may have to be omitted, but a slice of bread 3x3x½ in. would add 10-15 grams of carbohydrates as would also half a cupful of oatmeal or other cooked cereal. There is certainly nothing complicated in such a diet. It will allow of sufficient variation and if we desire to run up carbohydrates we can at the same time lower the fat content. I am still inclined to refer to past experiences a bit, and once a week have a meat free day and once in two weeks when the patient can be quiet and inactive, a starvation day. These days, I feel, temporarily take the load from the carbohydrate metabolic mechanism and help to promote tolerance.

DIABETIC DIET

Food	Amount	C.	P.	F.	Cal.
Meat, med. fat	2 slices 3x3½x¼ 150 Grams	.....	28.4	38.7	476.3
Egg	1	.....	6.7	5.3	76.8
Cottage Cheese	2 Tablespoons	1.7	8.4	.4	45.1
Milk	1 Glass	9.0	5.9	7.3	128.0
Am. Cheese	1 two inch cube	.1	11.5	14.4	181.5
Bacon (cooked)	4 Slices	.....	4.6	13.4	139.0
Butter	2 oz.	.....	.6	51.0	476.8
Cream (18%)	4-6 oz.	8.1	4.5	33.3	361.4
Mayonnaise	1 Tablespoon	.....	.1	9.1	82.3
10% Vegetables	1 Cup	17.8	3.8	.6	94.2
5% Vegetables	1 Cup	7.8	2.6	.6	48.2
Grapefruit or	½ Medium	8.6	.4	.3	39.7
Orange or	1 Medium	___	___	___	___
Apple or	1 Small	.....	.....	.....	.....
Strawberries	½ Cup	.....	.....	.....	.....
1 Slice Bread	I Slice 3¼x3x3/8 inches.	10.5	1.9	.2	52.7
		63.6	79.4	174.5	2109.6

Substitute for:
Bread

Rolled Oats (raw)	2 tablespoons and 1 teaspoon
Farina (raw)	1 tablespoon and 1 teaspoon
Cornflakes	¾ cup
Soda Crackers	5 Crackers
Zweibach	2 Crackers
Boiled Rice	2 Rounded Tablespoons

Estimated by Marian Peterson, Director of Dietetics, Jewish Hospital, Cincinnati, Ohio.

150 Grams	C	P.	F.
Meat (Med. fat)		28.4	38.7
Chicken		26.4	11.4
Fat fish (salmon, etc.)		34.2	18.2
Lean fish (white, etc.)		33.2	1.2

In offering this most simple program, I do not wish to add another dietetic formula. I want only to offer suggestions for simplicity. In doing so we may better control the patient when he is up on his own resources. A too rigid diet may drive him to a total disregard of our rules. It is possible that we may restrict him too much through fear. In the latter instance we take away a very considerable enjoyment of his life. In no disease is it more true that we must treat our patient as well as his disease. Let us be cognizant of the fact that in the treatment of diabetes we are transporting a chronic patient upon a long journey and the seas may or may not be rough and stormy. It should be our purpose to make his trip pleasant and comfortable as well as safe.

711 DOCTORS BUILDING.

DISCUSSION

HENRY J. JOHN, M.D., Cleveland: I have listened with interest to Doctor Heyn's paper and I can fully sympathize with the man in general practice who sees in the literature so much material coming out monthly on the subject of diabetes, which in the past decade, has come so prominently into the foreground. It is impossible for one interested in general medicine to read all these newer publications and when he does read many of them he must feel somewhat at a loss to differentiate between the controversial points. We must, however, look upon this mass of information with enthusiasm, for it is a good sign and it has one ulterior motive, to reduce the treatment of the patient to a final simple phase. This work in the meantime is necessary, as we must be sure of our ground, and the more we learn about what not to do, the safer will we feel in doing the simple and the right thing.

Doctor Heyn speaks of the various routine treatments, the high carbohydrate, the high fat diet, etc., with good results reported from all. I have just returned from the Pacific Coast, where, as you know, the high carbohydrate feeding was stimulated in this country, and I am glad to be able to tell you that it has been discontinued. As a matter of fact, traveling over the country and seeing what the various workers in the diabetic field are doing, show that we are each year closer and closer together. The average routine, which most men are using today, is approximately 100 to 150 grams of carbohydrate, 60 to 80 grams of protein and 1800 to 2500 calories for the adult patient. This, I think, is a very sound and a very liberal routine. Personally, I do not approve of the low carbohydrate, high fat diets. They are

not logical. I wish that any man using this routine, would go on it for at least a week himself and I dare say he would never again prescribe a low carbohydrate, high fat diet. (Laughter). This is the test of any therapeutic procedure. I have always felt that we have no right to institute a routine which we ourselves would not follow, if we had the same affliction.

I am afraid that men often get lost in a maze of detail and lose sight of the few underlying basic principles in the treatment of diabetes. The principles are important, the detail is comparatively unimportant and can often be altered at will or according to circumstances. In this manner the whole problem becomes simplified and rational. Take for example, the keto-antiketogenic ratio about which much has been written. It was a splendid piece of work, but you do not need to calculate the carbohydrate, protein and fat content of food according to the accepted formula. One can simplify it. If you give the patient at least 100 grams of carbohydrate in his daily ration and see to it that he actually burns most of it, you don't have to bother about the ratio for that automatically takes care of itself. The main thing is to keep the patient sugar free and if you do this you will have accomplished 90 per cent of all that can be accomplished with all the laboratories and all the formulae.

The problem of treatment of diabetes is primarily a problem of educating the patient. He must learn about diabetes, he must learn about diets if he is to plan his diet and his routine. Your and my problem is to teach him how. I think it is a good plan to place a diabetic manual of some kind in his hands and teach him systematically how to take care of himself, as in this manner you will get an infinitely better cooperation from him and he will go at his problem intelligently. It is fallacious to split straws, so to speak, in calculating diets. As Doctor Heyn pointed out to you, the analyses of individual foods vary considerably so that the error in this alone is probably greater than the error which the patient will commit in the routine course of weighing or approximating his diet. It is very important to give the patient enough to eat, for otherwise, when he leaves the hospital, he will not follow the routine and all your work is wasted. Doctor Banting is supposed to have said to one of his medical friends: "If I had diabetes, I would go to my doctor and say: I am living on such and such diet, find out how much insulin I need to take care of it." I feel the same way about it. I do not mean that one should use a careless or excessive diet, but a reasonably livable diet, compensated with insulin is what the diabetic treatment really is.

One thing Doctor Heyn has said, I feel is not quite fair to Doctor Allen, namely, that his treatment has been deserted. We must remember that when Allen came out with his undernutrition treatment, there was a definite need for this. It was the logical thing then, and many patients who today enjoy life and carry on in a normal fashion, would not be here were it not for that treatment. The need for it ceased with the discovery of insulin.

In the end, I want to emphasize that we all are using more carbohydrate than we used to and that here is continually a closer and closer agreement in the routine all over the country. I have been using for eight years, as a typical diet, 100 grams carbohydrate, 60 grams protein, and 118 grams of fat, a total of 1800 calories. Now for two years I have been using, as a routine, 140 grams of carbohydrate, 60 to 80 grams of protein, 111 grams of fat, a total of 1800 calories. Where an increase in calories is required, I add this in fat. Such a diet is really quite liberal and quite palatable, and is more than I eat.

I wish to compliment Doctor Heyn on this interesting presentation, for he has evaluated the various treatments of diabetes over the past decades. His sincerity in helping to simplify the problem is obvious.

J. J. COONS, M.D., Columbus: Dr. Heyn had the consideration to send me an advance copy of his paper for which unusual courtesy, I am most appreciative.

The author has given us a practical and useful method of treating the true diabetic of middle age. His paper does not include the care of the adult or child who must depend largely on insulin for existence.

The caloric needs of the average individual, moderately active, weighing 154 pounds or 70 kilos are about 3,000 calories. By selection he or she chooses:—100 grams of protein; 400 grams of carbohydrates; 100 grams of fat. The error in estimating the caloric intake (cooking, etc.,) may be considered 20 per cent of what is accurate. The assimilation of the various carbohydrates varies a great deal, as the result of an individual idiosyncrasy. Observation of each patient alone settles this factor. Therefore, why go into surface area and complex formulas in arriving at a diet for the mild true diabetic of middle life. In the hospital or for the medical student or for proper impression upon the mind of the patient, we may determine the proteins, carbohydrates, and fats according to the ketogenic-antiketogenic ratio recommended by Woodyatt. The preparation and measuring of the food may be explained but as a rule, these procedures if not carried out before the eyes of the patient, become a matter of minor importance. The average general hospital is a poor place to take the mild diabetic for instruction as to how to take care of himself. Better results can be obtained at home with an interested wife, daughter or dietitian.

For the mild diabetic in middle life, concern need not be given to the ketogenic-antiketogenic ratio. The Woodyatt formula allows 1 gm. of carbohydrate to 2 1/3 gm. of fat. Newburgh and Marsh have increased the fats to three or four times greater than the combined proteins and carbohydrates. The excess of fats in both diets soon causes the patient to lose his taste for food. Sansum recommends a full nutrition diet giving sufficient insulin to take care of the hyperglycaemia. Instead of 2 to 4 gms. of fat to 1 gm. of carbohydrate, he prescribes 2 or more gms. of carbohydrate to 1 gm. of fat. According to Dr. John, Cleveland, Ohio, Sansum is decreasing his carbohydrate intake. At the same time, Joslin, Woodyatt and others year by year have been increasing the carbohydrates. In time, let us hope that there will be a common agreement. An excess of protein and fats if long continued promote atheroma of the arteries. The size of the dose of insulin required has no ill effect whether 15 or 50 units. Our aim should be to maintain a normal blood sugar. If more than 20 units, the insulin should be given twice a day ⅝ in the morning and ⅜ in the evening to avoid hypoglycaemia.

Of course, (1) *diet* is the chief factor in all diabetics of middle life. If the patient is over-weight he should be reduced to 25 calories per kilo until his weight is normal or better 10 pounds under the normal for a man with a normal weight of 154 pounds. (2) Physical exercise is almost as important as diet. (3) Chronic infections should

be excluded. (4) Mental worries and cares lower the tolerance for carbohydrates. (5) Acute infections, such as carbuncles and boils greatly increase the amount of insulin required during the active stage of the infection.

The mild diabetic may have no complaints. The onset is insidious and the disease pursues a chronic course. Thirst, loss of weight, polyuria, etc., may be absent for years. The patient may be shocked to find he has a glycosuria after a health or life insurance examination.

In beginning treatment, the patient should be warned of the graver complications ensuing should the disease be allowed to run its course untreated. If at all possible, weigh and measure the food-intake for a few weeks until the patient obtains a fair knowledge of his requirements. Not one in a hundred will stick to a strict routine. Too many meals are eaten away from home. We may allow the mild diabetic 5 and 10 per cent carbohydrates with protein and fat or sufficient food to keep the weight near the normal for age and height. Use insulin as required.

The patient should be given careful and minute instructions. Joslin's Handbook for the Diabetic has proved most helpful.

The mild diabetic should test his own urine before the morning and evening meals. By experience he soon knows the amount of insulin required to keep the urine free from sugar and the blood sugar within normal limits granting healthy kidneys.

B. W. Abramson, M.D., Columbus: Dr. Heyn's paper constitutes, in my opinion, a challenge to the general practitioner.

When it comes to the treatment of diabetes, I always give the following admonishment to my patients, that only fools die of diabetes, and to the doctors, I would say that only indolent and mentally lazy physicians can fail in handling the ordinary diabetic cases. It is important that the physician should know the fundamental principles of diabetes as a disease, and the cardinal rules of its treatment. Then the physician is able to impart his knowledge to his patient in a way that the patient can easily follow his instructions. It is also timely, in my opinion, to warn the physician, as well as the patient, not to rely so much upon the use of insulin. Insulin should be regarded only as an emergency agent. Some patients believe that they can be indiscreet with their diet and break the rules given to them by their physician because insulin can counteract the results of their indiscretions. To illustrate, just about two weeks ago, a lady suffering from diabetes came into my office and said, "Doctor, I want you to give me a shot of insulin." I asked her how she knew that she needed insulin and she replied, "I just ate about one half pound of cake which I should not have done, but I know that insulin will correct the effects of it." This is a dangerous sense of security on the part of the patient which often leads to the breaking down of the general routine in the diabetic treatment.

I am glad that Dr. Heyn's paper attempts to simplify the matter of diabetic treatment. It speaks well for a better success in the management of our diabetic cases.

Removal of the Right Cerebral Hemisphere: A Case Report

John D. O Brien, M.D., Canton, Ohio

In 1928, Dr. Walter E. Dandy of Baltimore, Maryland, reported five cases in which he removed the right hemisphere for infiltrating tumors, all of whom died shortly after the operation; one case dying of hemorrhage, another of infection, a third from recurrence of growth three months later, a fourth of pneumonia, a fifth of an intracranial infection four months later. This being an operation of great magnitude, is apparently not attended with any immediate operative mortality in the series reported. The operation offers to those desirous of living under somewhat adverse circumstances, a prolongation of life, not attained by any other form of treatment, as exemplified in the case I am about to report.

The patient is a female, thirty-one years of age, the mother of two small children, always enjoyed good health. no history of any injury; complained of convulsions, generalized and again Jacksonian type, of ten years duration, attended with loss of consciousness, from two to four times a year, preceded by an aura of intense burning in the palm of the left hand. Later weakness of the left side of the body, blurring of vision, headache and emotional disturbance.

During two pregnancies, the attacks increased in frequency, and were altered in character, assuming a convulsive movement of the left side of the face, of greater frequency, and at times partially controlled by sedatives.

Two months before operation, experienced visual disturbance, deviated to the left in walking, headaches with vomiting appeared, diplopia, weakness of the left hand, dragging of the left foot, and twitching of the left side of the face and neck occurring every few minutes, deviation of head and eyes to the left.

In addition there has been marked emotional instability with frequent laughing and crying spells. The menses have been normal, and there has been no loss of libido.

A white, rather poorly nourished, short stature, adult woman; temperature 97.7; pulse 74; respirations 20; blood pressure 90/60. There was no significant physical findings.

Neurological Examination: Impairment of smell in the left nostril, visual acuity was di-

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Neuro-Psychiatric Pavilion, Mercy Hospital, Canton.

minished, and a left homonymous hemianopsia was present; choked disc of 2 diopters in the right eye, and 1½ diopters in the left eye; pupils equal and reacted normally. The ocular rotations were full and there was no nystagmus. Weakness of the muscles of mastication on the left side and a left lower facial palsy. Hearing was normal. A diminution of tactile perception over the entire left side, including the face; pain, thermal, position, vibratory, stereognostic perception were entirely lost on the left side; a moderate, spastic paresis of the left arm and leg, with increase of deep reflexes; the abdominal reflexes were absent. There was a bilateral ankle clonus and a left Babinski.

The spinal fluid pressure was 300 mm. of water; no abnormal findings.

Roentgenograms of the skull disclosed an atrophy of the posterior clinoids and dorsum sellae, and on account of the very definite localizing signs, an encephalogram was dispensed with; a clinical diagnosis of tumor (large in size) involving the Right Temporo-Parietal Lobe was made, and the patient was referred to Dr. W. James Gardner of the Cleveland Clinic, Cleveland, Ohio, for operation..

The following is a description of the operation performed by Dr. Gardner on August 31, 1931:

With the patient in the sitting position, a large horseshoe shaped flap of scalp, with a wide pedicle, was reflected from the right frontoparietal area, the sagittal limb being at the midline. The flap included the pericranium and temporal muscle. With the Souttar craniotome, a section of bone four and one-half inches in diameter was removed. The dura was moderately tense, and through the dura a dark area in the cortex could be seen in the temporoparietal region. With a rongeur, a considerable amount of bone was removed from the temporal region down to the level of the floor of the middle fossa, following which the dura was opened widely. A cauliflower-like cortical tumor was exposed in the temporoparietal region. The tumor was exceedingly fragile, dark in color and very vascular.

The tumor was definitely infiltrating in character. It was partially cystic, the contained fluid being yellow and coagulating on standing. The tumor was found to be very extensive subcortically, and it was obvious that nothing short of an excision of the entire hemisphere would prevent a recurrence. After consultation with the relatives, it was decided to proceed with an excision of the right cerebral hemisphere. The emerging cerebral veins along the sagittal sinus were therefore secured by means of ligatures and silver clips, following which the vessels were cut and coagulated with the electrosurgical unit.

It was necessary to remove additional bone with the rongeur in the superior anterior portion of the exposure in order to control bleeding from a pacchionian body. With retraction by means of a lighted retractor, the occipital pole was dislocated forward and upward, and three emerging veins on the inferior surface of the occipital lobe were ligated and cut.

The posterior portion of the hemisphere was then retracted outward, and an incision was made with the Majestic unit through the cortex on the medial surface of the hemisphere about one cm. above the corpus callosum.

The branches of the anterior cerebral artery were secured with silver clips as they were cut. The incision was then carried posteriorly around the splenium of the corpus callosum through the medial surface of the occipital and temporal lobes approximately one cm. from the midline.

The branches of the posterior cerebral artery were secured by silver clips. The frontal lobe was then retracted outward, and the incision carried about the anterior genu. When this had been accomplished, the operator turned his attention to securing the middle cerebral artery, which was accomplished from behind by retracing the temporal lobe outward.

By palpation, the middle cerebral artery was located about one cm. from its origin and clamped with a hemostat, following which the vessel was cut, and the hemisphere dislodged still further, in order to permit the application of a clamp to the branches of the anterior cerebral artery, which supplied the inferior surface of the frontal lobe. These vessels and the intervening brain tissue were then cut with the electrosurgical unit, and the hemisphere removed.

The removed tissue included the entire anterior and posterior horns of the ventricle and the outer wall of the body and descending horns.

A large portion of the choroid plexus was left in situ in the descending horn. The superior portion of the internal capsule as well as the outer portion of the caudate nucleus and the thalamus were removed.

The middle cerebral artery was then secured with a silk ligature and the inferior branches of the anterior cerebral artery by means of silver clips, following which hemostasis was complete. The remaining brain tissue appeared perfectly normal. The dura was then closed with a running silk suture, except for two small openings on the superior aspect. The cavity was filled with normal salt solution, following which the bone flap was replaced and held in situ with a single silk stitch at the superior margin. The scalp flap and temporal muscle were closed in the usual fashion.

During the course of the operation, the patient's blood pressure fell, but there was no increase in the pulse rate. She was given 750 c.c. of blood from a suitable donor, and about 800 c.c. of 10 per cent glucose intravenously.

The sitting position of the patient was found to very greatly facilitate the removal of the hemisphere. The sagging of the brain allowed easy access to the emerging cerebral veins and sagittal sinus. The bony opening, however, was found to be rather small for adequate exposure.

The patient reacted very well. A few hours after operation, she recognized and talked with friends. Forty-eight hours after operation, a cerebrospinal fluid leak occurred through the incision. The wound was then dressed and fluid aspirated from the operative cavity by a needle introduced through the scalp. This procedure was repeated from two to four times daily for four weeks. The patient's convalescence was very gratifying although there was a daily rise in temperature to 100 degrees until the time of her discharge 51 days later. Bladder and rectal incontinence was present for two weeks after operation. The blood pressure, pulse and respirations were not greatly altered by the procedure. At no time during convalescence was there any evidence of mental impairment. No emotional instability was observed postoperatively. The patient was optimistic, bordering on euphoria. She





spent part of her time reading and writing. There were no further convulsions or headaches and the patient was very grateful for the relief. At no time did she ask about the recovery of the left arm and leg. About five weeks after the operation, the patient began to take a few steps with the support of two nurses. A week later she was able to walk the length of the ward with support. The left leg was spastic but there was definite flexion and extension of the thigh and leg in walking and she was able to bear her entire weight on it. There was no voluntary movement in the limb when the patient was lying in bed.

Fifty days after operation, neurological examination disclosed the following: There was impairment of sense of smell on the left side as before. The visual acuity was 6/6 in the left eye, and 6/5 in the right eye. The choking of the optic discs had entirely subsided. A complete left homonymous hemianopsia was present. The ocular rotations were full. The right pupil was slightly larger than the left, but both reacted normally to light and accommodation. There was some weakness of the muscles of mastication on the left side. There was a moderate weakness of all the facial muscles of expression on the left side, but this was improving. The hearing was normal and equal on the two sides both with the tuning fork and audiometer. The soft palate was in the midline, the palatal and pharyngeal reflexes were normal and both vocal cords moved normally. The tongue protruded in the midline. There was a complete paralysis of the left arm and leg on voluntary innervation. The patient, however, was able to walk with support. The movements of the left leg were spastic and toe drop was present. During the act of walking, there occurred jerking movements of the left shoulder, but there was no motion of the arm and forearm. The deep reflexes on the left side were hyperactive. The left abdominal reflexes were absent. There was a positive Babinski response and an ankle clonus in the left foot. There was impairment of tactile, pain and thermal perception on the left side which appeared to be less marked in the face. Position and vibratory perception were completely lost in the left arm and leg, and there was, of course, complete astereognosis in the left hand.

The patient was discharged from the hospital the following day and has improved steadily to date, three and one-half months after operation.

Pathological Diagnosis: The tumor proved to be Glioma (Spongioblastoma) Right Cerebrum.

PATHOLOGICAL REPORT

Gross: A. Specimen consists of a mass of tumor tissue from the right cerebral hemisphere weighing 65 grams. It is non-encapsulated, irregular in outline, and approximately 5 cm. in diameter. It consists almost entirely of soft, friable, hemorrhagic tumor tissue with very little normal brain substance present. Scattered through the dark hemorrhagic mass there are irregular, firm, white homogenous areas. Blocks of tissue fixed in Zenker's fluid and the gross fixed in formalin.

B. Specimen consists of almost the entire right cerebral hemisphere, weighing 520 grams. On the external surface of the hemisphere at the posterior and upper portion of the temporal lobe, there is an irregular defect in the cortex roughly circular and about 5 cm. in diameter from which tumor A. above was resected or extruded. The margin of this defect consists of tissue similar to that described in A. and is continuous with an underlying tumor mass extending inward to the mesial surface of plane of resection of the hemisphere. There is no other tumor tissue on the external aspect of the hemisphere. The convolutions generally are somewhat flattened. The pial vessels are quite markedly injected everywhere. On the mesial surface the convolutions are intact. The plane of resection is through the outer border of the corpus callosum and includes the outer wall of the lateral ventricle but not the mesial wall nor the basal ganglia. Apparently the cingulate gyrus has not been removed. On this mesial surface at the posterior extremity of the lateral ventricle there is a rounded tumor mass displacing the outer wall inward. The tumor mass is approximately 5.5 cm. in diameter antero-posteriorly, 4.5 cm. vertically and 4.5 cm. transversely. Its posterior limit is 6 cm. anterior to the tip of the occipital lobe. Its inner border is covered in large part by the outer wall of the

lateral ventricle. Multiple transverse sections through the hemisphere show no tumor masses but large areas of intergyral hemorrhage in the occipital lobe. The structure of the tumor mass is similar to that described in A.

Blocks of tissue fixed in Zenker's fluid and the gross in formalin.

Microscopical: Sections A and B show a uniform type of tumor tissue having no characteristic arrangement. It consists of wide strands of closely packed, large cells having considerable pale, vacuolated cytoplasm and large round oval and irregular vesicular nuclei with loosely arranged chromatin. The cell borders are in general fairly well outlined by many cells in direct continuity. There are numerous fine and coarse protoplasmic prolongations but no fibril formation. The masses of tumor cells are separated by a fine vascularized stroma. Mitotic figures are fairly numerous.

Nine months after the operation, the neurological examination disclosed the following:

Impairment of the sense of smell on the left side remains. Left homonymous hemianopsia persists, with a slight reduction in the left nasal field. Hearing in the right ear 15 feet, and in the left 12 feet for whispered voice. Only a moderate weakness of facial muscles of the lower left side remains. Left arm is flexed slightly, with a contracture of fingers, and presents complete paralysis. Left arm is helpless, however in mass movements and recumbent, the hand and forearm are raised several inches. Left leg movements are spastic. Dysmetria is less marked than previous examination. Now stands alone; walks about house unaided, walks well with a cane; arises from chair with little difficulty; circumduction is not as sweeping in walking as before, tendency of foot to adduction is seen; gait is hemiplegic; general tremulousness in lower limb, at times coase oscillations are seen. Left abdominal reflexes are absent. Reflexes in the left arm and leg all active; irritative clonus, Babinski present to slight degree in left leg. No appreciable atrophy seen in muscles of left leg; has impairment of tactile sense, pain, and thermal perception on left side (arm and leg), appearing more marked than in the face. In upper face, can appreciate dull and pin point; however, over left chest and mammae, a hyperesthetic area is seen extending mesially to mid-axilla and ending at the twelfth rib anteriorly and posteriorly. Position and vibratory sense are completely lost in left arm and leg, while complete astereognosis, which existed prior to operation, persists. General physical improvement is seen, patient having gained more than fifteen pounds in weight since operation, and gradually growing stronger; mental status more alert, and a noticeable improvement in morale is seen.

This most amazing situation quite naturally offers the temptation to speculate regarding restitution of the opposite hemisphere. In the first case, restitution will be impossible since the same tissue is not replaced.

In offering a speculation, I am not only considering the pyramidal tracts alone, but offer other suggestions, based on the work of Foerster, Fulton, Goldstein and Monakow. Special difficulties and uncertainties regarding restitution are based on the entire lack of knowledge concerning the relation of the right hemisphere (infiltrated with a large tumor) to the functions of the normal or active hemisphere; particularly co-function. Broadbent first proposed the theory, and taught by Foerster today, that other parts of the brain may assume the lost functions of speech, motor power, etc. I cannot subscribe to this view entirely. Victor Horsley strongly opposed Broadbent's views. Goldstein and others strongly opposed Foerster's views on restitution. Monakow expressed himself against the assumption that the other hemisphere replaces the obliterated hemisphere. Mingazinni believes there is support coming from the cortico-calloso scapular tract of the opposite hemisphere. In removal of one hemisphere, there are still left the homo-lateral pyramidal tracts which are of some service, and I believe due to the latter, the hemiplegic learns some innervations (to a certain extent) and is able to participate in the extra-pyramidal synergies. (Baboon) (Objective function) Anton reports the case of a girl six and one-half years old, with complete absence of the cerebellum. A cross section through the medulla, revealed a high grade hyper-development of the pyramidal tracts and of the lemniscus belonging to it. The funiculi gracilis and cuneatus also were enlarged. Monakow likewise reports two cases with similar findings; in addition, in his case, decussation of pyramidal tracts began in the pons. The localization of definite areas in the cerebellum for the control of several parts of the body is much more diffuse than is the case in the cerebral cortex, since the cerebellum regulates the entire motor pattern of the act, while the motor cortex of the cerebrum controls the purpose. The synergic control of the cerebellum is essentially ipsolateral; axial and trunk muscles are under a bilateral dependent control, both halves of the cerebellum being active in the regulation of their movements. The synergic control of the appendicular muscles is both bilaterally dependent and unilaterally independent, the unilateral independence being more prominent in the arms than in the legs.

It is not surprising therefore, that in the efforts to determine an exact functional localization in the cerebellar cortex, so much more difficulty has been experienced than has been the case in the cerebral cortex; it is exact for circumscribed or limited acts; it is however, on the other hand, apparently diffuse and probably without definite limits for the great majority of volitional performances carried on by the muscles, and may provide an answer for some of the questions in this case.

SENSATION

Sudden interruption resulted at first in loss of sensation, which was followed by its more or less return, at first of pain, position, pressure; subsequently it is lost; astereognosis which existed prior to the operation remains the same. Tactile agnosia is not entirely characteristic of cortical lesions occurring in various cord lesions, thalamus disorders likewise.

In restitution of certain sensations in cortical resection, the fact must be considered that the afferent conducting tracts end not only in the contra-lateral hemisphere, but also in the homolateral side of the brain.

This naturally brings up the question of how much of the brain can be removed without impairment for example, of speech, etc.

Dr. Dandy, in a personal communication, relates the removal of the entire left temporal lobe, amount of tissue and tumor weighing 130 grm. Four months after the operation there was no defect of speech; at no time did the patient have auditory aphasia; profound anomia appeared following the operation, which has since disappeared. It has been taught, the center of auditory aphasia lies in the posterior part of the first and second left temporal; he believes the anomia was due to trauma of the parietal lobe. In a second case, the entire occipital lobe was removed, resulting one month later in visual aphasia; he had no auditory aphasia. The occipital lobe is associated with agraphia and alexia.

Summary of the results of cerebral extirpation in human beings, shows that auditory speech is located in the lower part of the left parietal lobe; that visual speech is entirely separate and distinct anatomically from auditory speech; that motor speech center is in Broca's area, originally described by him, just in front of Rolandic area, is possibly a little more posteriorly than heretofore believed. As a result of this series of operations, he concludes:

"It is possible to remove all of the right cerebral hemisphere, above the basal ganglia, with no appreciable disturbance of mentality, as seen in the amazing condition of this case.

"Both frontal lobes have been completely extirpated for treatment of bilateral frontal tumor, following which there has been no appreciable disturbance of mentality; patient is perfectly oriented as to time, place and person, memory unimpaired, calculated with a normal conversation. Furthermore, by the excision in other cases of the left occipital lobe and the lower third of the left temporal lobe, we are sure none of these lesions are responsible for intelligence. The intellect therefore is concerned with the remaining portion of the left cerebral hemisphere, and is doubtless closely related to the speech mechanism.

"It has been found after ligation of the anterior cerebral artery on the left side, consciousness is completely and forever lost. This does not result when the same vessel is ligated on the right side. There is, therefore, within the limits of the distribution of this vessel, an area specifically concerned with consciousness. The same result follows when this vessel is occluded at the middle of the corpus callosum, indicating that the seat of consciousness is posterior to this point in the vessel. The entire body of the corpus callosum may be split in the midline, without an appreciable disturbance of function. This structure is therefore eliminated from participation in the important functions, which hitherto have been ascribed to it."

We are taught that there is an auditory center for hearing in each temporal lobe; the total excision of the left temporal lobe shows that there is no auditory center in the left temporal lobe, while the removal of the right hemisphere disposes of the teaching that in the right temporal lobe there is an auditory center. In fact, this patient refers to her greatly increased sense of hearing, a voluntary statement on her part and likewise her family. Is there a connection between the tracts for hearing and the auditory center in the left parietal lobe?

Is the so-called Babinski as seen here, a primitive defensor reflex, with but little or no extension of toes, or does it arise from the extrapyramidal pathways?

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Motion pictures shown of this patient. N. B.—At the present time, (July 26, 1932), patient shows continued improvement.

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Neurology, by Peter Bassoe, M.D., clinical professor of neurology, Rush Medical College.

Psychiatry, by Franklin G. Ebaugh, A.B., M.D., professor of psychiatry, University of Colorado Medical School.

Pediatrics, by Isaac A. Abt, M.D., professor of pediatrics, Northwestern University Medical School, in collaboration with Arthur F. Abt, M.D., assistant in pediatrics, Northwestern University Medical School.

Dermatology and Syphilis, by Fred Wise, M.D., professor of dermatology and syphilology, New York Post-Graduate Medical School and Hospital, and Marion B. Sulzberger, M.D., associate professor at the same school.

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Traumatic Neurosis Among Industrial Patients

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TRAUMA not only does structural damage; it also may influence the mind of the man traumatized. It creates new situations, releases latent tendencies, and so disturbs emotions, that somatic symptoms may result.

The threat of danger in the traumatic incident stirs the glandular and autonomic reaction of fright. The resulting palpitation, the trembling, the weakness, the pain from the injured area induce introspection. The former self-assurance of well-being is replaced by self-doubt, and the introspective attitude finds in the swollen, discolored tissues cause for fear. Fear grows into anxiety; the most unpleasant complications pass in review during the waking hours, while more terrifying scenes may disturb the sleep at night. Symptoms revolve in a vicious circle forged by fear.

The care and kindness showered upon the injured individual, the unusual attention that he receives from doctor, hospital, and family, are all flattering to the ego, while the suffering may serve as an acceptable sacrifice for an inner sense of guilt (Levy-Suhl).[1] The fright, the pain, the anxiety may awaken a dormant antagonism against the employer—an antagonism which calls for revenge and justice. This desire for justice is translated into a demand for compensation. Thus compensation serves as a three-fold goal: money, victory, and approval.

Traumatic neurosis, therefore, passes through various stages in its development. From a fright stage, the symptoms become "agglutinated" through fear. (Kennedy[2]). Anxiety which arouses and is aroused by antagonism engenders bodily symptoms which gain sympathy and shekels. (Fetterman[3]).

TYPES OF INDIVIDUALS AFFECTED

It is true that not many injured working men and women develop this disturbance. The exact percentage is uncertain, yet authorities mention that there is a growing frequency (Shultze[4]). I have found it convenient to divide the individuals affected into two groups: pre-traumatic and post-traumatic, according to whether or not there was a positive deep-set basis. In the former, the trauma plays but a slight role, in the latter its part is significant. The individual with the pre-traumatic neurosis has had a deep-set, pre-existing mechanism, while the mechanism in the latter group is superficial. The pre-traumatic group is composed of those whose balance between health and neurosis is shaky. Either they have inherited a poor nervous structure or their training may have been faulty or perhaps their autonomic nervous systems have been weakened by illness, exhausted by fatigue and toxins, or their drive for happiness unsatisfied and thwarted. The slightest trauma may therefore bring into prominence a severe neurotic illness. The other group is composed of more or less normal individuals in whom the neurosis develops from the actual factors surrounding the trauma. Lottig[5] names this group "pseudo-neurotiker".

SYMPTOMS OF TRAUMATIC NEUROSIS

The many symptoms of traumatic neurosis may be grouped under three headings: local, systemic, and psychic. The local symptoms are centered about the part traumatized: bizarre, intense pains, paresthesias of heat and cold, peculiar numbness, tingling, weakness, abnormal fixation and postures. The systemic symptoms are widespread, as far-flung as are the actions of the autonomic system. They are frequently the result of vasomotor imbalance: dizziness, giddiness, ringing in the head, palpitations and sighing, trembling, muscular weakness, changes in digestion, sweating, coldness, even edemas. The psychic symptoms are those of anxiety and depression, self-doubt, irritability, sleeplessness, unusual fears about one's efficiency and health, a feeling of inadequacy, even of despair.

The symptoms may vary from time to time and will vary with the individual—often depending upon his power of description. In one individual they may fit into the subdivision of hysteria, in another, hypochondria or neurasthenia, but will all be included in the wider group of neurosis.

TIME RELATIONSHIP OF TRAUMATIC NEUROSIS

Such neurotic symptoms may make their appearance at almost any time interval after the trauma: early, many months after the injury, or even after the wounds have healed and the patient should be ready for work.

Among the susceptible individuals, the symptoms show up early, well-marked even at the fright stage. All of us know patients who have merely been exposed to dangers, startled, but not actually hurt, yet who have taken to bed for a long illness. Among those who have sustained marked organic injury — lacerations, severe sprains, fractures—the neurosis may enter insidiously weeks or months after the accident. The long days of invalidism with hours for meditation in which doubt and despair color the outlook offer a fine opportunity for an anxiety state ("precipitation point" of Shaller and Sommers"). Among other workers, the neurosis first appears when the physical damage has been repaired and the individual should be ready for work. Such

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patients have developed a dread which sees clearly, or what is more likely, magnifies the dangers inherent in their jobs. They fear to return to an atmosphere which reminds them of their recent "catastrophe" and threatens them with another injury. Such individuals withdraw from their jobs, yet do not quit as cowards, rather they develop physical complaints which serve as a protection for the ego. Cohen[1] cited his experiences with South African miners, stating that traumatic neurosis is extremely frequent among them and offers as the cause the fact that the men dread to return to the ever-present dangers of mining.

The following three case histories will serve to illustrate the type of individuals affected, the point at which the neurotic illness appears and the outstanding symptoms.

Case No. 1. Pre-traumatic type: symptoms hysterical. The patient is a young woman whose health record was that of an emotional individual, troubled by many illnesses. At puberty she was ill for almost a year with an unknown ailment. In her later teens, she developed many complaints which excused her from school and from work. She describes herself as introspective, studying her various symptoms carefully. On one occasion, she made a misstep in alighting from a street car and sustained a sprained ankle which somehow caused a disability extending over many months.

In the present accident, while working in a shop, her foot was caught in a hole in the floor and she sprawled to the ground. As she was lying on the ground, she was scolded by the foreman for carelessness. She cried hysterically. When she arrived home, she complained a great deal about the ankle and knee. The attending physician could find little pathology to account for the many symptoms. For weeks the patient was confined to bed. For over a year she used crutches, complaining all the while that the leg was so weak, so cold, so numb. And during this year, she developed an ever-increasing list of symptoms—head was throbbing, dizzy, sometimes seemed to grow larger then apparently smaller; she was sleepless; sometimes she couldn't swallow, couldn't breathe, heart beat violently. These and other symptoms have already lasted eighteen months.

This case history illustrates the deep-set neurotic mechanism which became released as a neurosis upon the provocation of a minor traumatic experience.

Case No. 2. Pre-traumatic, sustained organic damage, neurotic symptoms developed at the "precipitation point". Symptoms of anxiety neurosis.

J. U., age 40, window cleaner with fairly good work record, had sustained one previous injury many years before with prompt recovery. In the present instance, a ladder slipped under him and he fell, sustaining a knee injury consisting of a torn medial ligament of the knee joint. He was referred to a capable orthopedic surgeon who repaired the tear by open operation. A cast was applied and this was followed by physiotherapy. The patient was making splendid progress.

Some three months later, the condition turned for the worse. The patient complained of more pain than ever and that the leg was growing weaker. He mentioned also cold and numbness which kept him awake at night. Objective examination showed excellent healing and no obvious pathology in the knee joint. As time went on, there was marked irritability and depression. His questions reflected a serious self-doubt—"Will I really be better? Will I be able to take care of my children? I am afraid my knee is going to bother me. I know a man who had this injury and he has been off from work for many years. The doctor shouldn't have operated on me. The company did not treat me right. I think the stitches are going to bother me and cause trouble. Everybody is taking advantage of me. I am going to fight this thing through." Later, other complaints of sleeplessness, indigestion, and impotence showed up.

This case illustrates the type of industrial patient who has sustained actual damage and who, in the period of meditation, influenced perhaps by the pessimism of friends, develops a fear state. His disability arouses a latent antagonism against his employer. He grows suspicious of everyone. He seeks legal advice, becomes an adversary who fights with his symptoms.

Case No. 3. Post-traumatic type, with organic changes which healed well, the symptoms showed up at the return to work period.

Patient, aged 32, painter by occupation, had a good health and a fine work record. One day, he fell from a scaffold fracturing several ribs. During the convalescence, an over-anxious wife cautioned him repeatedly about the dangers of his work. She reminded him that his own father had died (of heart trouble), about a year after a chest injury. Both of them believed that the chest injury was the cause of the heart failure.

However, as the ribs healed well and the pains disappeared, he give little heed to these fears and returned to work. Unfortunately, his first job was to paint the ceiling of the Cleveland Public Auditorium, from a scaffold eighty feet high. The overhead work caused pain in his arm. The unusual height reminded him of his recent fall. It frightened him. As he worked and as his arm grew tired, the admonitions of his wife re-echoed in his mind. What if he should fall again?

The arm grew weaker, more numb and painful. He complained to the foreman about the pain. He was referred to a physician who diagnosed the case as traumatic neuritis. He ordered rest, massage, and electricity. The patient drew compensation for this condition for one year.

A careful examination revealed that this arm was normal in color and contour, muscle tone, power, reflexes; sensations all were normal. An inquiry into the patient's thought processes elicited promptly the fact that the arm symptoms served as a means of escape from an unpleasant situation.

Careful explanation to this patient with assurance that his arm was well, plus a change to ground work rapidly effected a cure.

TREATMENT (PREVENTIVE—ABORTIVE — CURATIVE).

The aim of treatment is to check or to subdue the growth of those factors which favor the neurosis. This includes calming the patient in the fright stage, removing his fears, subduing if possible the antagonism, eliminating the dangers

of his work, and settling the question of compensation. Such a program, splendid in theory, is most difficult to attain. In the pre-traumatic group, the ego needs the illness and will not relinquish it. Again, the course of emotional processes is not easily changed. Also, much of the program is not within the province of the physician—there are important social and political responsibilities, as pointed out by Eliasberg.[8] Lastly, many patients, suspicious by nature, reject such efforts.

Yet, if one would prevent traumatic neurosis the effort should be made, for the advanced case responds but little to treatment, and the woebegone sufferer limps from doctor to doctor, from lawyer to lawyer, from court to court, sour, embittered, and paranoiac.

The industrial surgeon who thinks usually in terms of structural processes must also be alert to the many disabilities that come from the emotions. During the course of his treatment he must distinguish one from the other, for they may be intermingled. The need for a most thorough examination is imperative if one is to recognize early a neurosis after trauma. In some cases, as for instance in those who have sustained head injury, the distinction between psychogenic and structurally conditioned symptoms is most difficult.

This examination should include some inquiry into the patient's interpretation of the injury and into his attitude towards those concerned in it. A study of the "credo" may guide the physician as to how much he should tell the patient of the extent of his injury. The industrial patient who has sustained a slight back sprain may dread its permanent crippling affect; he who has received a chest injury may think of a fatal tuberculosis; contusions may loom in the mind as tumors.

A doctor's opinion solemnly given may fix the patient's fears, especially if there have been previous experiences and tragedies which have made him sensitive. In a critical review of Wilhelm Stekel's work on Anxiety Neurosis, Karpman[9] expresses this significant idea: "There are many unhappy people who die, not of arteriosclerosis, but of its diagnosis". Similarly, I have seen many industrial patients suffering a long period of disability after back injuries, not from the slight fracture of the transverse process which was present but from their interpretation of the diagnosis (broken back). Indeed, one able orthopedic surgeon in Cleveland withholds, sometimes conceals from the patient himself (of course, not from the family) a diagnosis of a slight fracture of the spinous or transverse processes, lest the patient get the conception that he will be a cripple for life from a broken back. Hoffmann[10] even cautions against giving to the patient certificates of disability that emphasize the gravity of the illness.

There is intermingled with the symptoms frequently, the feeling of resentment, a spirit of antagonism towards the employer. This resentment makes an adversary of the patient, an adversary who fights with his symptoms. Consequently, if it is in the power of the physician through his position as a leader or through his diagnostic opinion to alter the antagonistic attitude, traumatic neurosis will be less likely.

Firms which treat their men well have less trouble with this complication. This is the thesis emphasized by Slater[11] who reported but three cases of this illness among seven thousand employees of the Eastman Kodak Company over a period of years. This excellent record is attributed to the splendid spirit which exists between employer and employee. The industrial surgeon who is confronted with traumatic neurosis should look to the care which his company is showing towards its men.

Often, the industrial surgeon meets with resistance on the part of the patient. This may be due to the fact that the patient's attitude of antagonism towards the employer extends to the physician as well. In such cases, it is best to allow the patient to select his own physician and to recommend early psychiatric consultation.

For the more advanced cases of traumatic neurosis, the usual treatments of neurotic patients in general are indicated. There is no specific. Treatment must be individualized. Sedatives in one instance, suggestion in another case, education in a third, change of employment in a fourth, and sometimes intensive psychotherapy,—each should be tried in the hope of restoring the patient to usefulness. Some will respond; others will resist treatment. The item of compensation may stand in the way of success. Jolly[12] mentions that the percentage of cures is rather high where lump sum settlement is made, while it is rather low where the individual draws weekly compensation.

In my own experience, I recall a prompt cure of a case of hysterical blindness, (previously reported,[3]) by suggestion, effected through the agency of faradic current; the painter, case No. 3, this report, who dreaded the high scaffold was restored to usefulness by a change of occupation. An Italian laborer (referred by Dr. A. Miller) who after a superficial foot injury asked for an operation to relieve the pain and weakness was cured—not by an operation but by education. A severe neurosis after a neck sprain was aided by similar psychotherapy plus an insistence upon a lump-sum settlement (private insurer). Such favorable results are few . . . most advanced cases remain chronic.

SUMMARY

This paper calls attention to the ever-present complication of neurosis following trauma. It points out the developmental nature of the illness:

starting in fright, passing through an anxiety state towards its goal; sympathy and compensation. The distinction between two types is made. It emphasizes the need for prevention and outlines treatment.

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The Prophylactic Use of Episiotomy In Primipara

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WITH the advent of our present day surgical technique, many obstetricians have recognized the usefulness of episiotomy in obstetrics.

Among its warmest advocates is DeLee, who states in his text book that perineal tears occur with a frequency varying from 9 to 75 per cent as put by different authors, and forceps labors show 54 to 85 per cent. He further states that in his own experience an anatomically absolutely intact perineum is a great rarity, but extensive lacerations are uncommon because he uses the episiotomy often.

R. H. Pomeroy voices his opinion in regard to episiotomy in the following manner: "We as gynecologists have devoted years of thought and much ingenious labor to planning and executing operations for the establishment of tolerable conditions in unhappy women disabled by childbirth, but thus far, we as obstetricians have not faced and accepted a reasonable responsibility for the discovery of a plan to prevent by some surgical procedure serious birth divulsion damage to the structures in the pelvic outlet . . . Why should we consider it other than reckless to allow the child's head to be used as a battering ram wherewith to shatter a resistant outlet? Why not open the gates and close them after the procession has stopped?"

Jewett has been quoted as saying that no method yields better results for the ultimate integrity of the perineum than episiotomy rightly timed and properly executed. B. M. Anspach once made the statement that the ultimate condition of the pelvic floor after episiotomy correctly performed, was even better than any natural delivery in which the parts escaped rupture. The tonicity of the structures frequently remained as perfect as in the nonparous woman.

Knowing as we do that few primipara escape injury to the vaginal outlet in delivering a full term child, and knowing as we do that as gynecologists, we are constantly treating patients complaining of ailments originating "since the baby has been born", we must seek methods and means to prevent the more serious injuries. We must appreciate that it is poor medical judgment to allow the baby's head to force its way out into the world by tearing all the structures in its path, if it cannot stretch them sufficiently. Then too, every time we apply forceps we increase the diameter of the passenger thereby further increasing the burden on the birth canal and the structures of the pelvic floor which must resume their very important function of support for the pelvic organs following the delivery.

The question is often raised "should we make so many of our deliveries surgical procedures?" If we are to elevate obstetrics above the category of old-fashioned midwifery and if our ultimate goal is to discharge our patient with her birth canal as nearly to its pre-pregnant state as possible, then we certainly cannot afford to be timid about such a simple procedure as episiotomy. The answer is obvious.

Then what of the baby? Certainly many babies have been lost in the final step of transformation from an intrauterine to an extra-uterine existence. Cerebral hemorrhage and other fatal injuries to the baby are not infrequent at this stage. In the majority of cases when not due to vigorous and faulty application of blades, it is due to an excessive pounding of the baby's head on a resistant perineum, especially when a premature rupture of the membranes has occurred.

It would be erroneous to assume that the episiotomy would prevent all injuries to the pelvic floor and perineum, but if the incidence of some of the tragedies of childbirth can be lowered by its more frequent use, then certainly it should be

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From the Obstetrical Department, Mt. Sinai Hospital, Cleveland, Ohio.

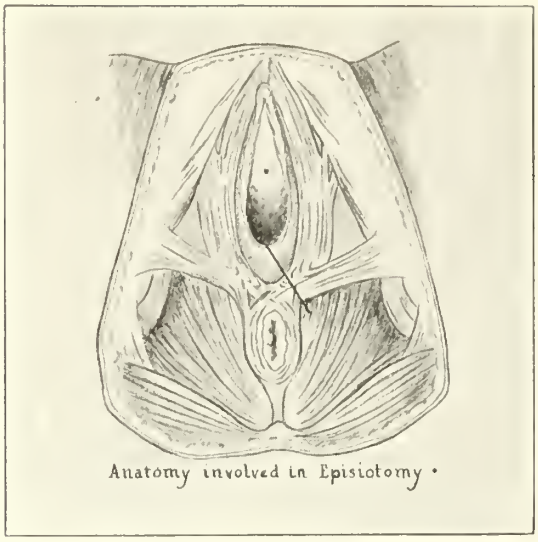


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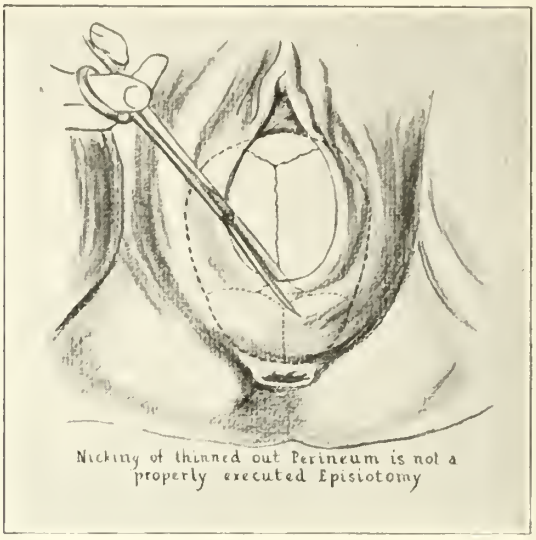


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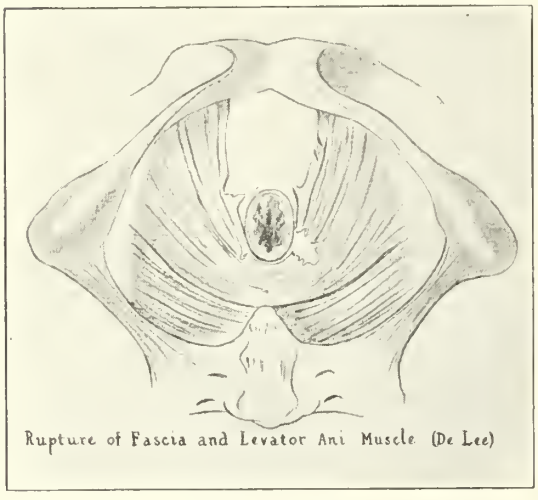


PLATE No. 2



PLATE No. 4

considered of greatest value to the obstetrician next to the obstetrical forceps.

I shall not attempt to discuss the different types of episiotomies and the many methods of their repair. However, a clear understanding of episiotomy as referred to in this paper is not amiss.

By episiotomy we mean the incision of the perineal body extending from the vulvar ring downward and obliquely outward, avoiding the anus and its sphincter, and includes the cutting of the pelvic fascia, the constrictor vaginae, the transversus perinei muscles and sometimes fibers of the levator ani muscles. It is exceedingly important not to confuse the above defined operation with the "nicking" or cutting of the vulvar ring after the occiput has balloned out the perineum following a great deal of stretching, and simply must have a larger orifice. This procedure would be nothing more than a slight cut in the mucous membrane and skin, and is not what we recommend for episiotomy.

An anatomical study of the vaginal outlet and the pelvic floor following a delivery is very revealing.

According to many observers the levator ani muscles with its superior and inferior fascia is almost invariably damaged in labor at term, and yet a careful study of its anatomy and its relation to the pelvic organs, immediately impresses one how vital it is to the well-being of the patient to have its structure conserved as much as possible. C. R. Hannah stresses its importance by stating that the uterus is supported in its position by the pelvic floor and not suspended from above.

According to DeLee, the intercolumnar fascia which holds the two levator ani pillars in their relation to the rectum, vagina, perineum, and each

other, is the seat for the most common form of pelvic floor injury. This injury it must be remembered, can and often does occur without any evident laceration of the perineum, so that the diastasis of the two pillars occurs and the site for a rectocele formation is established, in spite of the fact that the delivery may have been pronounced "without lacerations".

When the injury is more marked and includes not only destruction of fascia but also involvement of levator ani muscle, the integrity of the entire pelvic floor is interfered with and there is a tendency to prolapse of the pelvic organs with the formation of a cystocele and rectocele.

In addition we have the frequent vulvar tears that are so familiar to all obstetricians. While these seldom result in serious consequence, it leaves the vagina open and invites infection.

Last but not least is the third degree or complete laceration of the perineum into the rectum. Smith and Linton in their study of complete lacerations found 64.6 per cent were in primiparous patients. They also noted that to date (1929) there has been no decrease in the number of cases seen yearly.

A very important consideration and one which has been overlooked by many obstetricians is that of the most advantageous time for the performance of the episiotomy. As practiced by many, it is performed when the perineum is thinned out to paper-like thinness when the greater part of the damage to the pelvic floor has already been done. For this reason, these obstetricians have concluded that the episiotomy gave them no better results than the repair of lacerations. However, I firmly believe that if performed earlier, before any appreciable stretching of the perineum has occurred, the results would be more satisfactory.

When labor has completed its first stage of complete dilation and canalization of the cervix, the membranes having ruptured, and the head is visible resting on the perineum, the patient is ready for delivery. The patient is then completely anesthetized, prepared, and draped. With the aid of a lubricating oil or jelly, the perineum is gently and gradually ironed out. This paralyzes and relaxes the muscles and prevents further tearing of the episiotomy wound. The position of the head is then ascertained by direct manual examination and the episiotomy is performed. Bleeding from the incision is negligible, and easily controlled. The enlarged vaginal orifice thus permits of a more prompt and proper application of blades, allows the operator more room for the execution of maneuvers for the treatment occipitoposterior positions, podalic versions or breech extractions. Immediately upon the completion of the third stage of labor, the episiotomy wound is inspected and sutured, approximating the parts anatomically. At Mt. Sinai the method found best for the repair of the episiotomy wound is as follows: After the placenta has been delivered, the soiled drapes changed for clean ones, and the cervix examined, the vagina is swabbed with iodine and alcohol and a perineal pad inserted to keep the wound free of blood from the uterus. The free edges of the episiotomy are then sutured in layers. Beginning at the apex of the wound, the mucous membrane is sutured with a continuous chromic catgut suture up to the hymenal ring. The cut edges of the levator ani muscles are next sutured using either an interrupted or continuous suture. This is followed by a layer of subcutaneous tissue and finally the skin. The object at all times is to coept the sides of the wound as nearly to its original state as possible. Care must be taken not to insert the skin suture too tightly as that will cause edema of the skin, and pain.

SUMMARY

Nearly every primipara about to deliver a full term baby is benefited by the use of episiotomy rightly timed and correctly performed, even though she may be blessed with a roomy pelvis, good expulsive powers, and good tonicity of structures of the vaginal outlet.

To re-emphasize some of the advantages of the prophylactic episiotomy the following facts may be enumerated:

1. It prevents some of the more serious damage to the pelvic floor and perineum, thereby lowering the tendency to rectocele, cystocele, prolapsus uteri, and many other complaints associated with childbirth.

2. In as much as few primipara escape injury to the perineum the obstetrician can anticipate the laceration and direct the wound where he desires it.

3. It is only logical to assume that a clean cut wound anatomically repaired will give much better results than an irregular jagged wound whose edges are severely contused.

4. Episiotomy is the best means we have of reducing the incidence of third degree lacerations.

5. The second stage of labor is shortened, thereby lowering infant mortality and maternal morbidity.

6. The enlarged vaginal outlet of the episiotomy affords us means for a more prompt delivery should any emergency arise to warrant undue haste. It also affords more room for the several maneuvers in treatment of abnormal positions.

7. Episiotomy although a comparatively simple procedure is best applied in a well regulated maternity ward with the patient completely anesthetized. The lying-in period is not prolonged and patients usually can be out of bed on the tenth day, if so desired. Pain at the site of incision is very seldom marked, and many patients do not complain of any pain whatsoever.

CONCLUSION

Episiotomy is indeed a prophylactic step towards better obstetrics and if we are to accept the opinion of Jewett that episiotomy is the operation of the young obstetrician, then it is just a question of time before it will be universally adopted as an adjunct in nearly all primipara deliveries.

10616 EUCLID AVENUE.

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II. Discourse on a Visit to the Keeper of the Records

By SOCRATES ASKLEPIAN

—Master, they do say of you in the Temple of Health that you oppose progress and that you do stand against a newer and therefore better ministration to the sick by the priests.

—A strange accusation, Janus, when but yesterday they did say I do corrupt the young by failure to hold them to the ancient worship. What, pray you, are the words of their charge?

—They do charge you with opposition to the questioning by the priests of the pilgrims to the Temple, and the noting of their answers upon wax and papyrus and the storage of these in the Temple.

—Mean they that I stand opposed to the recording and the charting of their sufferings in imperishable form? That I am, Janus.

—Then you admit the accusation and do make yourself one with the hoary past when but yesterday you taught in the contrary; and you do declare yourself out of sympathy with that which has made Rotarios, our new order, successful even to beyond the Pillars of Herakles?

—Words come to you easily, Janus. They seem to me to fog the sunlight of your charge; but to discover the truth the more quickly let me admit the right of your accusation.

—You stand opposed to the making of a material record of the origin, the heritage, the monetary status, the faiths and the life histories of the pilgrims and of the discoveries which the priest does make by regarding the facies, feeling the pulse, touching the abdomen, seeking the signs of inflammation and viewing the excrement?

—That I am not, Janus.

—But did you not just speak contrariwise?

—An example within yourself, Janus, of how weakly the novitiates in natural philosophy are likely to reason. I do not object, I do urge the priest to make such record of every pilgrim who ventures to him, because even a priest's faculty of memory may need such prop.

—Then why said you otherwise before?

—Because the problem as you presented it was a different one; for though erstwhile you spoke of records made and stored in the Temple, you speak this time of records made by the physician and stored in his tunic or conscience. I hold that the second are alone useful, observant of the interests of the patient and protective of the public weal.

—And the first?

—As evil as the second are meritorious.

—Will you elucidate such contrary thinking for us?

—I object to records not because they are records but because of the place in which they are held. Hence I do oppose the gathering of such records where the conditions do conspire to make them public or where their storage does not permit them to remain private. What more than one knows, Janus, all know. I will myself, in speech with a pilgrim, permit not even you to be amanuensis; and as to my notes, I mark them with the pictures that the men of Egypt use lest in my peripatetic ministrations they fall from my tunic and thus into hands that can decipher common speech.

—But does not the Temple vault give greater safety than your tunic?

—That is the claim, Janus, but the fact is to the contrary. The virgins attendant upon the sick do fill the empty moments of their service in perusal of them; the novitiates of healing do ponder them in order more rapidly to learn the arts of Asklepios; and the priests oft decipher a tablet before knowing it not to be their own.

—But what meant you by holding such records useless?

—The graving of records, Janus, destroys time. Wherefore the old priests make them not, but leave the process to the younger. The product is therefore valueless, and on two counts: Temple notes like wines taste of the vessels in which they are made and while one may not be better than another it will, at least, be different. Thus will the products of one priest's observa-

tions be different from those of another; further, a pilgrim seeks consolation from a certain priest and will not therefore bare his burden to another nor to an acolyte—especially in the presence of the nurse-virgins. I hold that any record thus blurred by the additions or subtractions of another's mind or thus incomplete is useless to the high priest for whose guidance in action it is intended.

—But why hold you such records as opposed to the patient's interest?

—Because he is a soul that must dwell in a community of souls. Care you to have the weaknesses of your flesh or of your character bared in the market?

—I do ask for catharsis of the priests of Apollo.

—True, but in the faith that the priests do not publish abroad your confession.

—I begin to observe the direction of your argument, Master. You mean that without the trust to secrecy the pilgrims to the Temple of Health will also revolt at confession.

—Exactly, Janus. Imagine the pilgrim to be one of our Asklepian sect who in weakness of the flesh eats Lethe's flowers. Think you that the public knowledge of his demeanor would aid his recovery or make faster the faith of his worshipers in his—or our—ministrations; or consider an apoplectic in whom you have recorded in your observational acuity a faltering of the judgment. See you not that if your record could be torn from you it would invalidate all his human acts from responsibiiity for jury duty or murder to the disposition of his properties?

—I begin to see, Master. Without trust in the inviolateness of his communication the pilgrim to the Temple makes no confession and without confession he gains not catharsis and therefore no cure. I see how it would lose for him all that great good which the healers can bring him.

—Exactly, Janus.

—I begin to observe that unless kept strong in the ancient faiths the public must suffer.

—And I, Janus, that unless kept thus strong, the physicians will.

The American Association of University Professors has received a grant of $20,000 from the Carnegie Corporation to make a survey of the teaching now being done by college and university teachers.

Graduate courses for physicians are now being given in fifteen of the 21 counties of New Jersey under the auspices of the New Jersey State Medical Society and the Extension Division, Rutgers University.

The Committee on the Grading of Nursing Schools plans to continue its work for two more years if funds can be obtained for that purpose, according to a recent announcement.

Anti-Vaccinationists and Cultists Responsible for Bad Smallpox Record in Ohio

An article reviewing smallpox conditions in Ohio, the United States and in Europe over a period of years was published recently in the *Ohio Health News*. It follows in part:

A remarkable contrast is shown in a recent U.S. Public Health Report in the number of smallpox cases during 1930 in the United States and England as compared with the number in Continental Europe. The League of Nations also published a graph comparing this prevalence and makes the following comment:

"The efficacy of smallpox vaccination in preventing and limiting smallpox outbreaks is clearly shown by the progressive decline or even eradication of smallpox in counties of central and eastern Europe where vaccination has become general, while the disease still persists, or even spreads, in England and the United States, where vaccination is not in fact compulsory."

In 1930, 46,712 cases of smallpox were reported in the United States and 11,839 in England and Wales. Ohio contributed 5,111 cases as her disgraceful share. Ohio has numerous conscientious objectors, antivaccinationists and cultists, and, as shown, smallpox; the countries of Continental Europe have these antis undoubtedly, but they have also rigidly enforced compulsory vaccination laws. The results follow:

Country	*Population 1930*	*Cases of smallpox 1930*
Germany	62,348,782	2
Austria	6,675,283	0
Belgium	8,060,189	0
Bulgaria	5,596,800	0
Denmark	3,550,651	0
Sweden	6,141,671	1
Switzerland	4,018,500	1
Norway	2,890,000	0
France	40,745,000	217
Total Population	140,026,876	Total cases 221
Ohio	6,646,697	5,111

The following table shows the effect of the enforcement of compulsory vaccination in a few European countries and also the progress of smallpox in Ohio over a period of years.

Year	*Germany*	*Italy*	*Lithuania*	*Rumania*	*Ohio*
1920	2,042	26,453	1,213	3,467	7,209
1921	688	4,644	1,035	2,744	7,286
1922	215	534	345	865	2,422
1923	17	495	25	89	2,415
1924	16	432	58	9	5,597
1925	24	195	22	28	4,018
1926	7	112	11	6	2,133
1927	4	60	7	4	1,558
1928	2	52	10	10	1,236
1929	1	8	5	4	3,223
1930	2	2	4	5	5,111

Last year, 1931, there were only 1,767 reported cases in Ohio, probably because the fuel was exhausted in many localities, but even this is a greater number than was recorded in all these European countries combined and with the addition of Egypt, Ceylon, Japan, Siam and New Zealand.

The most energetic measures of quarantine and isolation have always failed to check a smallpox epidemic; nothing but the exhaustion of fuel to keep it going or vaccination to prevent its ignition will do the work.

The President's Page

A Personal Communication to the Membership from

H. M. Platter, M.D., Columbus, Ohio

As county medical societies go into high gear after the summer slow-up and vacation days, I would recommend an early meeting to discuss the practice of preventive medicine with particular emphasis at this time on immunization and vaccination. Children returning to school should be adequately protected against communicable diseases. These measures properly belong to the practicing physician and should only be employed by governmental agencies for the protection of indigents. The membership should be stimulated to render this service at this time. To request Boards of Health to institute a campaign of general immunization without regard of financial condition of the individual patient is a policy wrong in principle. It will create additional abuses and mis-understandings. Your attention again is called to policy on these matters in reports of the Committee on Preventive Medicine and Periodic Health Examinations.

Leadership should be developed in each county society to direct and support sound public health administration and modern medical practice. Through the medical society and by medical journals the older practitioner continues his education and keeps advised of modern medical procedure. Attendance at meetings should be stimulated. A reasonably regular attendance might even be made a requirement for membership. In this manner the level of the quality of service will be raised. Organized medicine should never be placed in the position of defending the practices of a physician who employs antiquated methods.

During this period of economic depression many demands will be made upon us. Much service must be rendered without hope of reward. These ministrations, however, will serve to emphasize and continue the intimate and confidential relation which should exist between the physician and his patient, and properly discharged will do much to refute the charge that the doctor has forgotten his obligations. While statesmen and economists debate and attempt to evolve a cure-all for our financial woes, as practicing physicians, we must discharge each day's duties intelligently.

As citizens we should make inquiry to determine the attitude of legislative candidates upon matters of public health and medical practice. Destructive measures enacted into law will result in harm to the public. Radical changes and panaceas in business or in medical practice should be viewed with suspicion. The history of medicine is replete with examples of exploded and discredited methods of treatment many of which are now seeking revival. I am sincere in the belief that modern medicine is discharging a constantly increasing service of benefit to the public, and I believe our membership will discharge their obligations and duties with credit to our profession.

In brief, my initial message is to interest yourself in the proceedings of your county society, use modern methods in treatment of disease, and vote for those candidates who will support sound measures as applied to public health and medical practice. Let it be said at the end of the year that we have kept the faith.

New Workmen's Compensation Regulations Applying to Physicians, Hospitals and Nurses Are Designed to Solve Existing Problems ≠≠≠ Promotion of Mutual Understanding and Cooperation, Urged

Confronted with a serious financial situation, resulting from factors accompanying the prolonged business unrest, and from a steady increase in the cost per claim for compensation and for medical, hospital and nursing services rendered persons disabled in employment, positive steps have been taken by the State Industrial Commission to safeguard the solvency of the Ohio Workmen's Compensation Fund, the disbursements from which have for some time exceeded the income obtained from premiums paid by insured employers.

The first step of the Commission to meet the situation was to increase the average basic rate Ohio employers must pay for coverage approximately 17 per cent in order to increase the income of the fund; thus, adding an additional necessary load on industry.

The second step was the tightening up of the rules and regulations governing the filing and approving of claims for compensation and the payment of physicians, nurses and hospitals for their services to disabled workmen.

Although the Commission, at this time, does not contemplate changing the flat rate fee schedule for medical services, it has revised the general rules and regulations applying to physicians, nurses and hospitals, so that the Commission will have a closer and more constant check on all claims for compensation and on medical, surgical and nursing services, and hospitalization.

It is pointed out that during the past year and a half, or two years, there has been a marked tendency toward the extension of periods of disability, the filing of questionable claims, and even malingering by workmen who now are unemployed or whose wages have been materially reduced.

Furthermore, it is declared that there has been a marked increase in the cost per claim for medical, hospital and nursing services and that a few physicians, hospitals and nurses have flagrantly violated rules and regulations of the Commission; have rendered unnecessary treatment to increase the size of their fee bills; have overcharged the Commission for services performed, and in some instances have been in collusion with employes seeking to obtain additional compensation or to establish a questionable claim.

While the Commission realizes that such abuses by physicians, nurses and hospitals are not general, it feels that it is necessary to make more strict its rules and regulations to prevent questionable practices and to conserve the resources of the state fund so that deserving claimants and honest, conscientious physicians, nurses and hospitals can be adequately paid.

Changes in the present rules and regulations, governing physicians, nurses and hospitals, and a number of supplemental rules have been under consideration for some time. Following a number of conferences with representatives of the State Medical Association, and a consideration of suggestions from a number of physicians throughout the state, engaged in handling industrial injury cases, the Commission officially adopted the following rules and regulations, effective September 15, 1932, and supplementing the present rules and regulations which now appear under the heading "General Information", on Pages 17 to 23, inclusive, of the *Fee Schedule Bulletin* issued by the Commission:

Rules and Regulations Governing Physicians, Hospitals and Nurses

(Effective September 15, 1932)

The following rules and regulations shall govern physicians, hospitals and nurses rendering services in cases for which claims for compensation have been filed:

Rule No. 1—It is the duty of the physician to submit a report of progress at least every 30 days in all cases where disability exceeds this period. Approval of bills will be based largely on the information given in the written reports furnished during the progress of the case, providing the reports disclose the actual facts.

Rule No. 2—If the claimant suffers from any disability or disease independent of the injury, it is the physician's duty to inform the Commission *promptly*.

Rule No. 3—Fees will not be approved for treatment by more than one physician or surgeon for the same injury or disability over the same period of time. This does not apply to consultants, anesthetists, assistants or cases where the need of an ophthalmologist is clearly shown.

Rule No. 4—A claimant shall not be permitted to change from one doctor to another or from one hospital to another without setting forth his reasons in writing and obtaining the written consent of the Commission for such transfer. A copy of such written request will be furnished the last attending physician or hospital. This does not apply to cases referred to a specialist by the attending physician when the nature of the case warrants nor to transfers made immediately following emergency or first-aid services. (See Rule No. 3).

Rule No. 5—Flat fees shall not apply to cases which terminate fatally within one (1) week after the date of injury but the fees approved will be based on the attention given as reported by the attending physician.

Rule No. 6—Fees for daily dressing will not be approved unless the proof of record clearly shows the necessity. (In most cases wounds heal much more rapidly when the dressing is not disturbed too often).

Rule No. 7—Fees for electrical treatments, X-ray treatments, massage and all other types of physiotherapy will not be approved unless written authority has been given in advance.

Rule No. 8—Upon the completion of treatment in all compensation cases, physicians shall promptly notify the Commission and, in addition thereto, shall render their final bills, on forms provided by the Commission, within sixty (60) days thereafter.

In cases requiring prolonged treatment, physicians may file partial bills, fully itemized, at intervals of sixty (60) days.

The questions on the reverse of Form C-19 shall be fully answered in all cases.

Rule No. 9—Except in emergencies or where the condition of the patient might be endangered by delay, consent from the Commission must be obtained in advance where plastic or reconstructive surgery is contemplated or where open bone surgery in the later reduction of fractures is required. No bills for major surgery will be approved, even when authorized, until a copy of the hospital record of operation has been placed on file.

Rule No. 10—No fees for hospital care for more than one (1) day will be approved where the proof on file indicates that claimant is ambulatory, unless the case is unusual in nature, in which event the attending physician shall explain in detail why additional hospital care was given.

Rule No. 11—When a claimant has reached the state where further hospital residence becomes a matter of personal convenience only, it is the duty of the hospital superintendent or executive to notify the Commission at once. When a claimant is confined to a hospital for an extended period, bills must be filed monthly with the hospital record covering the period of the bill.

Rule No. 12—No hospital bills will be accepted unless a brief history of the case sufficient to show the nature of the injury and character of the treatment is given on the face of the fee blank or attached thereto.

Rule No. 13—In cases of urgent necessity, a special graduate or registered nurse may be furnished for not to exceed seven (7) days. Written authority must be obtained in advance for all services in excess of seven (7) days. The fee for 12-hour duty is $5.00 and for 20-hour duty, $7.00. These fees include board on all hospital cases.

Rule No. 14—Fees for practical nursing service by a member of claimant's family or anyone else will not be honored unless written authority has been obtained in advance. The fee in each case will be fixed by the Commission.

Rule No. 15—The Commission reserves the right to reject bills for hospital, medical and nursing care unless proof submitted clearly shows the necessity of the services charged for.

Rule No. 16—When the medical limit of $200.00 has been reached, further fees for medical, hospital and nursing attention will not be approved by the Commission except in unusual cases, wherein it is clearly shown that the actual necessary medical, nurse and hospital services and medicines exceeded the amount of $200.00.

Medical Only Claims—Form C-3

The following rules shall apply to preliminary applications, medical reports and fee bills in cases where the claimant is disabled for less than seven (7) days:

Rule No. 1—In all "medical only" cases in which the medical treatment does not exceed two (2) weeks, Form C-3 shall be filed not later than one (1) month following the date of injury. If medical treatment is not completed at the end of two (2) weeks, the physician shall file Form C-3 at that time, submitting at the same time a complete report showing the need for further treatment, upon receipt of which the Commission shall furnish the attending physician with the file number of the case and with Form C-19 blanks to be used by the physician in making semi-monthly reports showing why treatment is continued and for filing supplemental fee bills. The payment of medical bills in cases requiring more than two (2) weeks' treatment will depend entirely upon the reports the attending physician submits to the Commission.

Rule No. 2—If any operative treatment other than first-aid or emergency operation is needed, a complete report shall be filed describing the condition and the operation necessary, and asking and obtaining authority for such operation before proceeding with it.

Naturally, the foregoing rules and regulations will require more "paper work" in connection with prolonged workmen's compensation cases. However, they are expected to have a beneficial effect in stopping flagrant abuses and questionable practice by a few physicians and others whose attitude in dealing with the Commission has necessitated tightening up the regulations.

Moreover, these new regulations should be helpful to physicians who are systematic and make reports and submit fee bills promptly, and should minimize delays in the payment of compensation and medical bills.

The Commission realizes, and is appreciative of the fact, that it has received the whole-hearted cooperation of the medical profession generally. However, the Commission in revising its rules and regulations could not, for obvious reasons, make exceptions. The rules must apply to all physicians, all hospitals and all nurses.

Actuary's Statement on Fund

The necessity for prompt action on the part of the Commission to remedy the serious situation confronting the fund was crystalized pursuant to the completion a few weeks ago of the annual actuarial statement on the condition of the fund as of December 31, 1931, and the announcement by E. I. Evans, chief actuary for the Commission, that for the first half of 1932 the disbursements

from the fund had exceeded the fund's income by approximately $2,000,000.

Mr. Evans' statement reveals that during the year 1931 the total assets of the state insurance fund were reduced $5,335,784.97. The reserve for pending and incomplete claims showed a reduction of $3,509,656.69. The general surplus of the fund actually was reduced from $2,117,962.22 to $750,568.58 during 1931, a total reduction of $1,367,393.64, while the statutory catastrophe reserve was reduced from $2,346,-899.06 to $1,883,563.35, due in a large measure to the heavy drain upon the fund from claims of injured employes of those employers who failed to insure in the fund and were financially irresponsible.

The serious problem to which the fund is being subjected is further emphasized by the actuary's statement relative to income and disbursements for the years 1930 and 1931.

In 1930 the receipts, premiums and interest earnings of the fund totaled $14,004,755.54 while the disbursements for that year totaled $16,165,-029.67, revealing an excess of disbursements over receipts of $2,160,274.13.

An even greater excess of disbursements over receipts was registered in 1931 which showed a total income of $11,544,899.14, total disbursements of $16,077,209.54, and an excess of disbursements over receipts of $4,532,310.40.

During 1931 receipts declined 17.6 per cent, reflecting the reduction in employment, factory payrolls and wage levels. However, disbursements declined only one-half per cent, disclosing the increasing extent to which claim reserves built up in former years of high industrial activity are being used to meet present payment of compensation claims and medical, hospital and nursing expenses of injured employes.

Mr. Evans pointed out that while this condition "was expected as disbursements are required for many years afterwards on accidents resulting in serious disability or death to an employe, and reserves have been provided in recognition of these obligations", the really serious problem at present is the fact that "there has developed an increasing tendency in cost of new claims as well as older claims due to the prolonging of the healing period and tendency to over-stress the extent of disability".

The statement reveals that the number of claims filed during 1931, a period of low industrial activity, declined but a fraction of a per cent more than the percentage of decrease registered for total payrolls and total premiums, as compared to 1930. The decrease in the number of claims filed was 20.1 per cent, while the decrease in total payrolls was 19.2 per cent and the total premiums, 19.5 per cent.

The following tabulation of the various types of claims filed with the Commission during the past 10 years shows, however, a marked decrease in the number of claims filed during 1930-31 and 1931-32, compared to the number filed in the preceding years:

Year	Medical Only	Compensation For Lost Time	Occ. Diseases	Total
1922-23	121,050	54,575	802	176,427
1923-24	122,323	58,354	933	181,610
1924-25	123,299	55,462	884	179,645
1925-26	142,551	63,516	1036	207,103
1926-27	152,411	65,396	1055	218,862
1927-28	146,361	59,753	1020	207,134
1928-29	170,141	68,041	1259	239,441
1929-30	179,335	62,772	1234	243,341
1930-31	132,911	50,918	1246	185,075
1931-32	108,179	43,709	1066	152,954

Referring specifically to a number of factors which have contributed to this serious condition, Mr. Evans said:

Cost Per Claim Increasing

"The fund is experiencing an abnormally increasing cost per claim in compensation to the injured employe, and in medical cost of attending physicians, nurses and hospitals.

"A great measure of this increasing cost burden is through the tendency of the courts and juries to allow cases on appeal and on review which have been disallowed, or compensation terminated by the Commission. These cases, before they were disallowed, or the compensation terminated, were

OCCASIONALLY, the State Industrial Commission receives a request from a physician for authority to perform an operation or provide some special treatment for an injured worker who has not filed a claim with the Commission.

In such instances, the Commission is without authority to authorize an operation or special treatment. Before the Commission can act in any industrial injury case, a claim must have been filed.

The Commission has suggested that physicians, when confronted with such instances, should exercise their own best judgment in the matter. If the condition of the patient warrants an immediate operation or special treatment, perhaps to save him from death or permanent disability, the Commission's advice is for the physician to proceed with adequate and proper attention. Later, when the claimant has filed his application with the Commission, the Commission will give due consideration to the physician's detailed report on why he considered the operation or treatment necessary, and approve his fee for such services, providing, of course, it is established that the injury was received in employment and that the medical attention given was necessary.

In such cases, physicians should be particularly careful in reporting the circumstances to the Commission and furnish a complete review of the patient's condition and the services which he rendered.

subjected to extended investigation in reference to the facts and the facts were thoroughly inquired into and reviewed by the medical and legal divisions of the Department of Industrial Relations previous to being finally considered and passed upon by the Commission. This condition has the same effect as legislation increasing the scope of the Act, bringing in types of claims that heretofore were excluded and extending benefits in other types. There is an 18 per cent increase during the year (1931) in the number of claims requiring reserves due to appeals from disallowance of the Commission.

"There is a marked tendency for some attending physicians and hospitals to prolong the treatment of injured workers and unnecessarily require special nursing services. This has resulted in the average medical cost per claim increasing 12 per cent during the past year and an increase of 20 per cent over 1929. This increase in the face of lowered wage levels resulting in lowered payroll to which rates are applied becomes a great factor in raising the rates to employers.

"The average compensation cost per claim has developed an increase of 6.7 per cent during the last year while the increase of 1931 over 1929 amounts to 9.4 per cent.

"During a period of depression when the injured employe's job is not available there is a tendency to prolong the recovery period into the period of unemployment. This is presenting a serious problem to the fund and demands the utmost cooperation of employers and attending physicians if the interests of those beneficiaries with meritorious claims are to be protected, and prevent the increasing of rates to employers to a point that will seriously handicap Ohio industry.

"The trend of reduced wage rates becomes a factor in reducing the premium income per man exposed as the rates are based upon the payroll of the employer, while the benefits do not decrease in the same proportion. Medical, hospital, nursing and funeral expenses are not based upon the injured employe's wage rate; also, while compensation is based upon the wage rate of the injured employe, the weekly benefits are not affected where wage rates are reduced from upper levels to levels above $28.13 per week due to the compensation benefits being limited to two-thirds of the weekly wage and not to exceed $18.75 per week. Therefore, the injured employes receiving $35.00 per week receive the same weekly benefits of $18.75 as those receiving $30.00 per week; also wage level fluctuations above $23.44 per week do not affect the amount of death benefits to dependents of killed employes.

"The fund is receiving an extremely heavy burden through being required to compensate injured employes of non-insured employers having three or more employes, due to the employer being financially irresponsible. As employers insured in the fund as well as self-insuring employers must meet this burden through contributions to the statutory reserve fund to which such losses are charged, all complying employers should lend their fullest cooperation in the enforcement of coverage on such employers.

"An employer is required to reimburse the Fund for additional awards granted to employes injured as a result of the employer's failure to comply with a specific requirement for the protection of the lives, health and safety of employes. In cases of financially irresponsible employers, this becomes an additional burden upon the fund, as no reimbursement is possible.

"The amount of payments by the fund on claims of employes of un-insured employers increased 15 per cent during the past year."

Medical Costs Higher

A statistical analysis of medical costs shows the increase which has taken place during the past few years in the average medical, hospital and nursing costs for various types of claims.

These figures reveal that the average cost of "medical only cases"—those in which the employe is disabled for less than seven days and for which he is not entitled to compensation—but which includes medical, hospital and nursing services, increased 13½ per cent in 1931 over 1929, the average cost in 1929 being $8.35 and in 1931, $9.47. Medical costs in all types of cases increased approximately 10 per cent in 1931, compared to 1930, and 21½ per cent compared to 1925.

A comparative study of medical costs in prolonged cases also was made. It showed that the medical cost on a claim during its second year of treatment was 67 per cent higher in 1931 than in 1925; approximately 50 per cent higher during the third year of treatment, and 150 per cent higher during the fourth year of treatment.

The regular five-year inventory taken in 1931 revealed that the Commission had on file 1163 cases in which the medical costs had exceeded $1000, compared to 1033 cases of this kind for the five-year period which ended in 1930, or an increase of 12½ per cent.

It was pointed out that in cases not over five years old, two have cost over $20,000 and eight have cost between $10,000 and $20,000 in medical, hospital, and nursing services. One case less than two years old, it was revealed, had cost to date $10,000.

Principles of Workmen's Compensation

The medical profession is, and should be, keenly and vitally interested in the efficient application of workmen's compensation which has become so well-established in Ohio as a social, economic, humanitarian and governmental principle.

Industry, which maintains the fund; employes for whom it is maintained, the public, and the medical profession which is closely identified with the administration of the state insurance fund are equally concerned in efficient administration, prevention of accidents and disease, conservation of the fund for the purposes for which it was intended, the maintenance of a harmonious industrial and employment situation in Ohio, adequate and efficient medical service for those incapacitated through employment, and prompt rehabilitation and return to employment of the beneficiaries of the law.

An indispensable part in the administration and application of the compensation law is played by the medical profession from a social and economic, as well as a scientific, standpoint. Employers, employes, and the public have a right to demand that the best medical, hospital and

nursing care available shall be rendered those disabled in employment, and that those providing such services cooperate fully in the administration of the law. Invaluable service has been given by the physicians of Ohio generally to beneficiaries of the law and with a few exceptions have cooperated constantly with the State Industrial Commission.

Physicians should not overlook the fact that workmen's compensation has been of great economic value to them. They have been compensated for their services to disabled workmen and in numerous instances have been paid for services rendered to workmen who would have been unable to pay physicians direct for their services.

Records of the Commission show that for a period of 10 years, 1922 to 1931, inclusive, a total of $27,745,484.98 has been disbursed from the state insurance fund for services rendered by physicians to disabled employes. During the same period, $10,175,013.40 has been paid out for hospitalization and nursing services, making a total of $37,920,498.38 disbursed for medical, hospital and nursing services.

Schedule of Disbursements

During the same 10-year period, the Commission has authorized the payment of $93,168,239.93 in compensation to injured or disabled workmen. More than one-fourth of the total disbursements from the fund during that time were made to physicians, nurses and hospitals.

The following tables show the disbursements from the fund for compensation and for medical, hospital and nursing services from 1922 to 1931, inclusive:

Year	Compensation	Medical (Physicians)	Hospitals and Nurses
1922	$ 5,236,596.11	$ 1,604,423.98	$ 427,645.89
1923	6,659,047.34	2,198,358.47	614,427.79
1924	7,974,790.64	2,268,777.74	700,068.97
1925	8,758,205.20	2,568,796.83	780,172.36
1926	9,265,486.20	2,813,555.23	874,551.47
1927	9,596,215.18	2,935,418.84	1,060,707.89
1928	10,078,932.83	3,074,752.06	1,258,579.47
1929	11,491,907.58	3,682,181.47	1,433,332.33
1930	11,876,276.50	3,390,547.24	1,500,928.56
1931	12,230,782.35	3,208,673.12	1,524,598.67
Totals	$93,168,239.93	$27,745,484.98	$10,175,013.40

Without the cooperation of the medical profession generally, the Commission would be seriously handicapped. Valuable and indispensable information used in the adjudication of claims is obtained from the reports filed by attending physicians.

Prompt, Complete Reports Vital

Prompt, accurate and complete reports by attending physicians are essential for efficient and equitable administration of the compensation law.

Delay and confusion in the settlement of claims has resulted through the laxity of some physicians in filing reports. The Commission must have a constant check on all claims. This cannot be accomplished unless the physician furnishes prompt and frequent reports on the condition of the claimant. In cases of prolonged disability, the Commission depends to a considerable degree on the medical reports to fix the amount of compensation to which the employe is entitled. Furthermore, it must be kept informed of the progress in the case in order to prevent malingering, inferior medical attention or over-treatment.

Laxity of some physicians in the filing of fee bills in "medical only" cases is a source of annoyance to the Commission. The only check which the Commission has on cases of this classification is through the C-3 blank. Since these cases as a rule do not involve large sums, C-3 forms are handled in a routine manner. However they are the most numerous type of cases filed and if permitted to accumulate disrupt materially the clerical work of the department.

Furthermore, if "medical only" blanks are not filed promptly the Commission is seriously handicapped in determining whether the injury was sustained in employment, since such injuries usually are minor in nature and the circumstances incidental to them quickly forgotten. Moreover, unless the physician files C-3 blanks promptly the Commission may be confronted with a large bill for medical services in a case about which it knew nothing.

Recently, the Commission received a number of "medical only" bills for medical care rendered employes who were injured as long as two years ago. In one case in particular, the physician's bill was for $500 for treatment of a sprained back, occurring two years ago and which did not keep the man off the job for more than one day. The Commisison knew nothing about this case until it received the physician's bill.

Officials of the Commission point out that since small bills for medical services are handled routinely, the physician will obtain his fees more quickly if he files bills at frequent intervals than by waiting for them to accumulate before filing.

The Commission is inclined to question large bills in cases where forms are not filed until long after the injury or termination of treatment. Also, it is pointed out that the Commission has found from experience that the best medical reports as a rule are those which are filed promptly —while the nature of the injury and the treatment given are fresh in the physician's mind, and that early reports tend to expedite authority from the Commission for necessary corrective operations or specialized treatments.

Importance of Medical Evidence

It is most essential that physicians file accurate and complete reports on all cases. Medical evidence is vital in the settlement of compensable cases and in the approval of bills for medical services. If the information furnished by the attending physician is inaccurate or incomplete, the

claimant may suffer long delay and much confusion may result. Occasionally the settlement of a case has to be delayed pending voluminous correspondence between the Commission and the attending physician to clear up conflicting data. As a result, the claimant has to wait for his compensation; the physician has to wait for his fee, and the clerical force of the Commission is burdened with unnecessary correspondence, consuming time that might have been used in handling other cases.

Frequently physicians fail to inform the Commission concerning any disability or disease independent of the injury which the claimant has sustained during employment. It is the duty of the physician to inform the Commission promptly of such disabilities or diseases since the handling of a considerable number of cases, records of the Commission show, has been complicated simply because the physician neglected to report other disabilities in addition to those resulting from the industrial injury.

Physicians need have no hesitancy in making full and complete reports on the physical condition of claimants. Under a waiver clause on all forms signed by the claimant, the physician is protected from suit by the claimant for libel or slander. The waiver clause was printed on such forms within the past year at the suggestion of the Committee on Medical Economics of the State Medical Association.

Officials of the Commission point out that they will be quite willing to cooperate with physicians who desire to make confidential reports to the department by arranging to have such confidential reports kept out of the file of the case, which is open to public inspection. Of course, such confidential reports should be made in communications direct to Dr. H. H. Dorr, chief medical examiner for the Commission, and not be made on the regular forms supplied by the Commission.

Promptness Essential

By filing prompt, accurate and complete reports, physicians can assist materially in accomplishing three things:

1. Effective administration of the compensation law and greater efficiency in handling all types of claims.

2. Greater speed in the payment of compensation to all payments and the maintenance of proper safeguards to the state insurance fund, to prevent malingering, fraudulent claims, etc.

3. More prompt payment of medical fees.

The Commission's desire is to cooperate fully with physicians who are themselves cooperative. Many physicians have complained that frequently they have difficulty in getting replies from the Commission on routine matters; that occasionally there is delay in obtaining authority for operations, special treatments, etc., and that fee bills are not paid promptly.

The Commission is aware of these complaints and has taken steps to correct these flaws by better systematizing the work of the clerical force and enlarging the department's personnel so far as its funds will permit. However, the Commission points out that physicians must be as patient as possible since in a department of that size, which handles thousands of claims every week, there are certain to be some delays and some degree of inefficiency regardless of any corrective measures which may be instigated.

Failure on the part of a few physicians to adhere strictly to the flat rate schedule of fees has been the cause of much delay and confusion.

The flat rate fee schedule covers the medical or surgical treatment rendered in the majority of claims filed. However, the Commission has been inclined to be lenient in its interpretation and application of the flat rate schedule. Where a physician has been able to show that an unusual amount of necessary treatment and care has been given, a suitable adjustment has, in most instances, been made.

Naturally, the Commission cannot be expected to make proper adjustments in fee bills unless it is fully informed of the circumstances and has adequate proof that the special care was necessary.

Itemized Fee Bills

Fee bills should be carefully itemized. Visits to the patient should be listed in chronological order. In cases requiring special and unusual attention, not covered in the flat rate fee schedule, the physician should make a complete report of these circumstances and conditions to the Commission.

The fee schedule is quite definite as to the fee for services rendered in the ordinary type of cases, and the rules and regulations governing medical, hospital and nursing services not only simplify the meaning of various items in the fee schedule but also inform the physician how to proceed in unusual cases.

Naturally fee bills cannot be paid until they are filed. The earlier the physician files his bill, the sooner he will be paid. The physician who is careless in making out his fee bill; fails to keep adequate and accurate office records on his cases, and is slow in filing his bills with the Commission should not expect prompt action by the Commission.

Abuses Discovered

In analyzing some of the factors contributing to increases in medical costs of workmen's compensation cases during the past few years, the Commission has discovered that a *few* unscrupulous physicians have been instigators of, or parties to, abuses which have tended to dissipate the state insurance fund.

The Commission has evidence tending to show

that a few physicians have falsified medical reports to aid undeserving or malingering claimants.

Typical examples of the practices resorted to by a few physicians to impose on the Commission and to obtain unwarranted fees are: Daily dressings for weeks and even months of an apparently minor injury; elaborate tests and examinations in cases indicating little more than first-aid treatment; unnecessary operations; prolonged physiotherapy and other treatments in cases where the claimant has not even stopped work; listing of services never performed.

The tendency toward over-hospitalization in workmen's compensation cases has created a financial problem for the Commission. A few physicians apparently regard every industrial accident case as a hospital case, whether or not hospitalization is indicated. In some instances, attending physicians are lax about having the claimant discharged from the hospital as soon as he may be moved with safety. Some claimants raise strenuous objections when dismissed from the hospital, indicating a desire to remain, despite their improved condition, so that they can take advantage of the free room and board and receive the special attention of the institution's nursing staff.

The Commission has on record a number of instances where medical investigators upon going to a hospital to examine a patient have found he has gone shopping or has gone home for a two or three days' visit with his family. In one instance, it was found that the patient had returned to work but was returning to the hospital each evening to spend the night.

Cooperation between physicians and hospital executives and the Commission to prevent such abuses is sought by the Commission. The new rules and regulations have been drafted in such a way that the Commission will have a better check on hospital cases and be able to minimize unnecessary hospitalization.

Physicians who resort to questionable and dishonest practices make themselves liable to prosecution under the fraud section of the Workmen's Compensation Law which provides fines up to $500 and imprisonment up to one year, or both, for persons convicted of making fraudulent representations to or filing with the Commission fraudulent claims, reports, fee bills, letters, evidence, etc.

The Commission is determined to put a stop to deliberate and malicious violations of its rules and regulations and has signified its intention to resort to criminal prosecution if the evidence warrants.

Problem of Assistants

Occasionally misunderstandings have occurred between physicians and the Commission relative to the payment of fees for services rendered by office assistants, technicians, or nurses employed by the Commission.

The Commission has officially ruled that "no fees will be paid to a doctor for services rendered by an assistant who is not a registered physician, unless the doctor is present and directly supervises the treatment".

This has been interpreted to mean that all services to injured workmen must be done under the direction of the attending physician and for which he is at all times responsible; that every physician must keep in close touch with every case under his care; must prescribe and supervise, through oral or written instruction, the treatments being given by his office assistants; must delegate to these assistants only work that they are qualified and legally permitted to do, and must assume direct personal responsibility for the services rendered by his office aides. However, this ruling does not imply that physicians

FREQUENTLY in the past, members of the State Association have been warned against doing business with so-called "industrial service bureaus", "workmen's compensation bureaus" and other types of agencies and bureaus who claim to specialize in adjusting cases before the State Industrial Commission.

During the past year, because of unsettled business conditions, a number of bureaus and agencies of this type have been extremely active in soliciting business not only from persons having claims before the Commission but also from physicians whose bills for medical services are pending.

These agencies have no standing whatsoever before the Commission. Most of them charge an exorbitant commission and some of them merely use the physician as a wedge to get at the Commission's files so that they may obtain the name of some claimant and data on his case in the hope of selling their extravagant service to him.

All claims and medical fees are paid as promptly as possible after final decisions are reached. The efforts of "service" bureaus and similar agencies add nothing to the speed of the procedure followed by the Commission and have no influence with the Commission in making decisions on cases.

The Commission prefers to deal directly with the physician himself, or if there is an undue delay or misunderstanding, with him through the Headquarters Office of the Ohio State Medical Association. The Commission is anxious to cooperate fully with the Headquarters Office in clearing up misunderstandings on the part of physicians.

must personally render minor services, such as simple dressings, treatment for minor injuries, simple laboratory tests, physicaltherapy, etc., which may be done by well-trained nurses and technicians, but merely that the physician shall supervise and be responsible personally for such services.

Occupational Diseases

Physicians should understand thoroughly the legal provisions relative to the reporting of occupational diseases and the handling of such cases, since these claims usually are complicated and require considerable investigation on the part of the Commission.

Under the Workmen's Compensation Law, as amended by the State Legislature in 1931, 21 occupational diseases or conditions are recognized as compensable. The present schedule, with a description of the processes involved, was published on page 728 of the September, 1931, issue of The Journal.

The policy of the State Association regarding occupational diseases and their compensability under the Workmen's Compensation Law should be familiar to all members of the Association, since the policy has been analyzed at various times in annual reports of the Committee on Medical Economics. Recent mention of this question was made in the 1930 and 1931 annual reports of the committee, published in the May, 1930, and May, 1931, issues of *The Journal*. In brief, the policy of the State Association is that a carefully prepared schedule of compensable occupational diseases should be retained in the Ohio law, in preference to a "wide open" occupational disease provision as advocated by some individuals and groups.

Under the Ohio law claims for compensation for occupational disease are barred unless the application for compensation is filed with the Commission within four months after the disability due to the disease began.

The law places a definite responsibility on attending physicians in reporting occupational disease cases promptly. Section 1465-99a of the law requires a physician attending a patient whom he believes to be suffering from an occupational disease, as defined in the law, to make a report of the case to the Industrial Commission within 48 hours from the time of making such diagnosis.

Any physician who neglects or refuses to make and transmit such a report to the Commission is liable to a fine not to exceed $100 or imprisonment not to exceed 90 days, or both. However, the law provides that no physician shall be imprisoned for a first offense.

Interpretation of Rules

In many cases, physicians apparently do not understand the rules of the Commission relative to the payment of more than one physician in the same case.

The Commission has ruled that fees will not be approved for treatment by more than one physician or surgeon for the same injury or disability over the same period of time. Of course, this does not apply to consultants, anesthetists, assistants, or cases where the need of an eye specialist, urologist, etc., is clearly shown, or where there is need of the services of a general practitioner for some condition following surgical procedure.

However, the flat rate fee for special operations, dislocations, fractures, amputations, etc., includes payment for subsequent treatment and aftercare by the physician or surgeon rendering such service.

Rules of the Commission on X-ray work are definite and clear, and should be thoroughly understood by all physicians, especially by roentgenologists. It is most important that all X-ray films and prints sent to the Commission be plainly marked for identification with the name of the claimant, name of the physician, and number of the claim.

Although the contract made annually between hospitals and the Industrial Commission provides that the hospital providing X-ray services may include the cost of the service in its per diem rate for hospitalizing workmen's compensation cases, this provision is not compulsory, and a considerable number of hospitals exclude X-ray services from their per diem rate certified to the Commission.

This is a question to be decided largely by the hospital and the roentgenologists on its staff. If the hospital excludes X-ray costs from its per diem rate, the roentgenologist should submit his fee bills directly to the Commission and they will be handled along with all other medical bills. However, if the hospital *includes* X-ray services in its per diem rate, the Commission cannot pay the roentgenologist, who must look to the hospital for his fee.

When corresponding with the Commission, physicians should, if possible, give the file number of the claim about which they are writing. In some instances, especially in "medical only" cases, the claim number may not be available. In that event, the name of the claimant, name of the employer, and date of the injury should be given.

Under the new rules and regulations adopted by the Commission, additional reports and correspondence will be required of the attending physician in some cases, so it will be essential for all physicians to file carefully all correspondence and blanks received from the Commission for future reference.

Importance of Cooperation

The problems and questions referred to in this article, and others which have been discussed fre-

quently in the past in *The Journal*, illustrate the necessity for full cooperation and understanding between the medical profession and the Industrial Commission.

Because of the splendid spirit shown and the honest and competent services rendered by the great majority of the physicians of the state in their dealings with the Commission, and because of the mutual understanding and cooperation which exists between the Commission and the officers, Committee on Medical Economics and the Headquarters Office of the State Association, the medical profession of the state generally is in an advantageous and favorable position in its relationship with the Commission.

A recent comment in the *American Medical Association Bulletin* on this point is particularly pertinent. Discussing workmen's compensation problems generally, that publication said:

"The states where medical relations appear most satisfactory are those in which active committees of state and local medical societies meet regularly with compensation administrators to discuss and settle disputed questions."

This is especially applicable to the present situation in Ohio.

The favorable position of the medical profession must be maintained and can be if every physician handling workmen's compensation cases renders competent and honest services and shows a willingness to assist and cooperate with the Industrial Commission.

As pointed out in a recent report of the Committee on Medical Economics, the medical profession of Ohio is in a much more favorable position with regard to operation of the principle of workmen's compensation than most other states, many of which have eliminated entirely the free choice of physicians in industrial accident cases and provide a definite time limit on the amount of medical service which shall be given in any one case.

Officials of the Commission state that compensation administrations from other states frequently ask how leaks and frauds are minimized in Ohio with its unlimited medical period, free choice of physicians, and other lenient provisions.

Their answer, these officials say, is: Because the medical profession of Ohio *generally* has cooperated with and assisted the Commission and has not taken advantage of the responsibility delegated to it by the Ohio law.

Rates which Ohio employers must pay for maintenance of the Ohio fund have not increased to the extent found necessary in many other states. At present the Ohio rates are at a lower level than those of many other states, despite the fact that the benefits under the Ohio law are more liberal than those of most other states.

Ohio employers are well aware of this. Moreover, they fully realize the social and economic value of good and adequate medical care for their injured employes. At the same time, they object to dissipation of the state insurance fund by evasion of the act by unscrupulous employers; by malingering employes and imposters, and by dishonest physicians, nurses and hospitals.

The harmonious conditions which now prevail in administration of the Ohio Workmen's Compensation Law can be maintained if rules and regulations of the Commission are observed and the questionable practices which have sprung up are eliminated.

Unemployment Among Graduate Nurses Attributed To Over-Supply — Other Economic and Educational Factors Discussed

The over-supply of nurses has created an unprecedented problem of unemployment in Ohio for the members of that profession, according to data and information assembled by the Ohio State Nurses' Association.

In 1930 there were 15,594 registered nurses in Ohio, since which time there have been graduated and admitted through examination, approximately 1,300 in 1931 and 883 thus far in 1932; making a total of almost 18,000 registered nurses in Ohio at the present time, or practically three times the number of registered nurses in this state in 1920.

It is pointed out that about two decades ago there was a need for more graduate nurses. Concerted efforts were made to interest young women to enter nurse training. That educational propaganda, accelerated through the war-time appeal, multiplied the number who entered nurse training to such a degree that in the past ten years there has been an increase, practically double, in the students in the accredited nurses' training schools in connection with Ohio hospitals. At the present there are 4,488 student nurses in Ohio's accredited nursing schools—103 more students than in the previous peak year. Statistics of the 76 nurse training schools in the State show that 42 have more student nurses, at the present time, than ever before. Of this total number, it is considered probable that three schools in connection with hospitals may be discontinued in the near future.

In a recent communication from the State Nurses' Association to the Ohio Hospital Association, it was stated that "The Board of Trustees of the Ohio State Nurses' Association desires to solicit the cooperation of the Ohio Hospital Asso-

ciation in aiding our Association in its endeavor to reduce the number of student nurses being accepted into schools of nursing; also in our endeavor to assist the small hospital having a daily average of less than 75 patients in planning to employ a staff of graduate nurses to care for patients".

The State Nurses' Association also pointed out that as shown by the report of the Duke Foundation, it is less expensive for the small hospital to employ a graduate staff than to maintain an accredited school of nursing.

According to officials of the State Nurses' Association, the fact that there are thousands of graduate registered nurses unemployed in Ohio at the present time is not accounted for by the present economic depression, but "to the fact that training schools have continued pouring out an increased stream of graduate nurses".

In justice to those considering entering the profession of nursing, as well as to hospital training schools and all others interested in adequate economic security for those engaged in the profession of nursing, the State Nurses' Association points to the fact that the previous appeal of nursing "as a profession rich in opportunity for advancement and for rendering a splendid service to mankind, as well as earning an adequate income after completing their course", no longer applies to the situation; and that for this reason, in order to avoid further sacrifice of quality among student nurses, the old system of supplying student nurses to hospitals will require modification.

As a conclusion to its official communication to the members of hospital boards of trustees, the State Nurses' Association declares that "we are sympathetic with our hospitals, because we understand the acute financial strain, but we are of the opinion that a more economical way can be found for caring for our sick in hospitals with less financial strain than by all hospitals conducting schools of nursing".

In connection with the entire problem, some of those who have given thought to the matter believe that a gradual decline in the number of student nurses will be generally beneficial, and that eventually requirements might be established to provide that those entering the nursing profession should have at least one, and probably two, college years as a preliminary.

Whereas in 1910 Ohio had four nurses per 5,000 population, it now has approximately twenty. Other statistics show that of all the women wage earners in the United States, one out of every twenty-four is a nurse.

In addition to the graduate nurses, there are estimated to be between 8,000 and 9,000 so-called practical nurses, so that with both considered there is one nurse in Ohio for every 273 persons.

In taking cognizance of the situation, Dr. H. M. Platter, secretary of the State Medical Board and the Nurses' Examining Committee, states that "Many well qualified registered nurses are out of employment. At the same time nurse training schools in Ohio have recruited students in greater numbers than in former years. Apparently, the supply of nurses at present is more than sufficient to meet the needs of the public for several years to come and the prospect of employment by nurses at the completion of their course is exceedingly remote. Formerly, during and after the war, effort was made to induce young women to enter the profession of nursing. It would seem that this effort should now cease. Practice as a means of earning a livelihood will probably not be possible to attain for a period of years".

* * * *

Some interesting observations were made in a recent report of the National Committee on the Grading of Nursing Schools regarding the demand for specialized nursing service and the necessity of preparing the modern nurse to tackle any kind of a task assigned her.

At least 15 per cent of all types of physicians, including the general practitioners, of a representative group of 4,000 queried by the committee, want the nurse to be especially familiar with a particular disease, the report pointed out. The proportion when the physicians were grouped by specialities was found to be higher than this among the neurologists, obstetricians and the ophthalmologists.

Commenting further on the recent investigation, the Committee's report said:

"There is a significant and close correlation between the practical experience in the basic services given to the student nurse in the training school and the subsequent satisfaction of physicians employing her as a graduate.

"The surgeons, for example, were found to be the group most contented with the quality of nursing they can obtain for their patients. In the 1397 training schools reporting on the activities of their students, by far the greatest amount of student time was spent in the surgical wards—often at the cost of reducing time spent in the other branches of nursing care.

"On the other hand, the pediatricians and the neurologists frequently express a lack of nurses who have had specific training in caring for their type of patients. In many schools, these services are slighted in the training of student nurses, and far less time is spent in ward practice among these cases than is the minimum requirement for a proper foundation of knowledge on the part of the prospective graduate trained nurse."

"That nurses themselves realize the need for specialized training is evidenced by the fact that there is a growing tendency among them toward taking post-graduate courses, after the full term of training has been completed, in such work as pediatric and psychiatric nursing," the report stated.

"The proper assignment of duties in the hospital to the student nurse, in order to insure sufficient experience in the major services," it is stated, "is still, however, neglected in many schools. As a result, the fact that a nurse is a graduate of an accredited school is as yet no guarantee that she has sufficient training in the basic types of disease to make her as valuable as she might otherwise be to the patient and doctor. The fear of being unable to cope with the job, because of lack of sufficient training, is one of the major reasons why nurses 'register against' certain types of cases. Physicians rarely find that no nurse is available when they want one, but they cannot always get the kind of nurse they feel is particularly needed for the case."

It is pointed out that probably most of the nurses who "register against" certain types of cases come from schools that have not enough patients to afford a proper scope and variety of bedside experience; have given students lopsided training; do not provide adequate supervision of student work by graduate nurses; utilize students' time for non-educational tasks, or give students too many patients to care for at once so that they have no time for more than routine bedside training.

In conclusion, the report recommends the adoption by all nurse training schools of all, or at least part, of the following standard curriculum for a three-year course, approved by the National League of Nursing Education:

5 months medical service (includes general medical wards and diet kitchens).

6 months surgical service (includes general surgical, gynecological, urological, orthopedic wards, and operating rooms).

3 months communicable diseases (includes work in special divisions for contagious diseases, tuberculosis, and venereal diseases).

3 months pediatrics (includes infant feeding).

3 months obstetrics.

2 months psychiatric and neurological diseases.

1 month eye, ear, nose, throat, skin and other specialties.

Northwestern Medical Meeting Lima, October 4

The annual Fall meeting of the Northwestern Ohio Medical Association will be held at Lima, Tuesday, October 4.

Among the speakers for an interesting and diversified program are: Dr. Wm. J. Dieckmann, Chicago; Dr. Ferris Smith, Grand Rapids, Mich.; Dr. E. D. Spalding, Detroit; Dr. A. Graeme Mitchell, Cincinnati; Dr. H. M. Weber, Rochester, Minn.; Dr. Herman Kretchmer, Chicago; Dr. R. B. Cattell and Dr. Frank Lahey of Boston.

The evening meeting following the banquet at 6:30 P.M. will be addressed by Dr. Lahey.

On Monday, October 3, a big day of golf at Shawnee is being planned by the Lima profession.

Fifth District Program

An interesting and attractive program has been arranged for the annual meeting for the Fifth Councilor District of the Ohio State Medical Association, which will be held in Cleveland in the Allen Memorial Medical Library, Euclid Avenue and Adelbert Road, on Friday, September 16, 1932.

The program follows:

MORNING SESSION

11:00 A. M.

Diagnosis of Pulminary Tuberculosis—J. C. Placak, M.D., Cleveland.

Diagnostic Errors in Pulmonary Tuberculosis—Richard Dexter, M.D., Cleveland

Medical Management of Pulmonary Tuberculosis—R. C. McKay, M.D., Cleveland

ORGANIZATION LUNCHEON

12:30 P. M.—Dining Room, Allen Memorial Medical Library

Euclid Avenue and Adelbert Road

Under the auspices of the Anti-Tuberculosis League of Cleveland and Cuyahoga County.

Dining Room, Allen Memorial Medical Library

FIRST AFTERNOON SESSION

2:00 P. M.

Surgical Treatment of Pulmonary Tuberculosis—S. O. Freedlander, M.D., Cleveland

Tuberculosis in Infancy and Childhood—Henry J. Gerstenberger, M.D., Cleveland and Herbert S. Reichle, M.D., Cleveland

Anemia of Pregnancy—V. C. Rowland, M.D., Cleveland.

Recess for Visit and Smoke

SECOND AFTERNOON SESSION

4:00 P. M.

Neurological Manifestations of Pernicious Anemia—M. A. Blankenhorn, M.D., Cleveland

Treatment of Pernicious Anemia—R. H. McDonald, M.D., Cleveland

Treatment of Secondary Anemia—R. D. Leas, M.D., Cleveland

DINNER

EVENING SESSION

(Combined meeting with Academy of Medicine)

8:15 P.M.—Allen Memorial Medical Library, Euclid Avenue and Adelbert Road

Introduction and Welcome

Harry G. Sloan, M.D., President, the Academy of Medicine of Cleveland

Greetings from the Ohio State Medical Ass'n.

H. M. Platter, M.D., President, The Ohio State Medical Association

Practical Points in the Diagnosis and Therapy of Pulmonary Tuberculosis—Gerald B. Webb, M. D., Colorado Springs

Social Hour—Buffet Supper

Dr. Harry V. Paryzek, Cleveland, Councilor of the Fifth District, is the chairman of the Local Committee on Arrangements. The other members of the Committee are Dr. R. S. Dinsmore and Executive Secretary H. Van Y. Caldwell of the Cleveland Academy of Medicine. Dr. H. M. Platter, Columbus, president of the State Association, and Dr. Clyde L. Cummer, Cleveland, president-elect and former councilor of that district, will participate in the meeting.

Industrial Accident Boards and Commissions to Have Interesting Program in Columbus September 25 to 30

Program for the Nineteenth Annual Session of the International Association of Industrial Accident Boards and Commissions, to be held at the Neil House, Columbus, September 26-30, has been announced by Wellington T. Leonard, president of the Association and chairman of the Ohio Industrial Commission.

The convention will bring together delegates from all states having accident boards and commissions, and from Canada and Porto Rico.

Speakers who are experts in their particular line of work will discuss problems connected with the administration of workmen's compensation funds, including discussions on premium rates, the necessity for adequate reserve funds, medical problems, establishment of weekly wage averages, etc.

During their stay in Columbus the delegates and their wives will be extended a series of entertainments. These will include a visit to the Museum of Fine Arts, a tea at the Governor's Mansion, a musical tea at the home of Mr. and Mrs. Emile E. Watson, tours of the Ohio Penitentiary, large department stores, Ohio Capitol, the A.I.U. Citadel, buffet supper at the Scioto Country Club and an automobile tour of Central Ohio on the closing day of the convention.

The program, drafted by Mr. Leonard, Joel Brown, Idaho, vice president of the Association, and Ethelbert Stewart, statistician for the United States Bureau of Labor Statistics, secretary-treasurer, follows:

Monday, September 26

9 A. M.

Wellington T. Leonard, Presiding.

Presidential Address—Mr. Leonard.

Appointment of Convention Committees.

Reports of Regular Committees.

2 P. M.

Joel Brown, Idaho, Presiding.

Review of Medical and Hospitalization Costs in Workmen's Compensation Cases, with Comments on the Lambert Committee Report—Frances Perkins, Industrial Commissioner, New York.

General Discussion.

6:30 P. M.

Banquet

Wellington T. Leonard, Ohio, Toastmaster.

Address of Welcome—Governor George White, Ohio.

Address of Welcome—Mayor Henry W. Worley, Columbus.

Address—Ethelbert Stewart, Washington, D. C.

Entertainer—Strickland Gillilan.

Tuesday, September 27

9 A. M.

A. B. Funk, Iowa, Presiding.

Some questions as to Ascertainment of What is an "Average Weekly Wage" Under Present Conditions; Its Relation to Premium Rates and Insurance Problems—Dr. Walter O. Stack, Delaware.

General Discussion.

2 P. M.

Charles R. Blunt, New Jersey, Presiding.

What is an Adequate Reserve—R. E. Wenzel, North Dakota.

Wednesday, September 28

9 A. M.

Swen Kjaer, Washington, D. C., Presiding.

Relation of Safety Codes to Industrial Accident Prevention—T. J. Duffy, Columbus, former member of the Industrial Commission of Ohio.

General Discussion.

Safety is Better Than Compensation—R. B. Morley, Toronto, Ontario.

General Discussion.

2 P. M.

Charles A. Nowak, Illinois, Presiding.

How Far Workmen's Compensation Acts Can Apply to Maritime Law, Interstate Commerce and the Doctrine of Extraterritoriality—Samuel B. Horovitz, Boston legal aid.

General Discussion.

The Legal Situation as to Second Injury Cases and the Necessity for Separate Funds for Such Cases—Charles F. Sharkey, Washington, D. C.

General Discussion.

Thursday, September 29

9 A. M.

Dr. H. H. Dorr, Ohio, Presiding.

The Department's Medical Advisor; Conclusions From an Experience of Ten Years' Service—Dr. C. W. Roberts, Georgia.

The Traumatic Head Case—Dr. F. B. Harrington, chief surgeon, Wierton Steel Company, Wierton, West Virginia.

Functional Neuroses; Their Nature and Relation to Injury—Dr. George T. Harding, Jr., Columbus.

General Discussion.

2 P. M.

Dr. G. H. Gehrmann, medical director, E. I. duPont de Nemours and Company, Wilmington, Del., Presiding.

Some Common Hazards in Industry—Dr. Emery R. Hayhurst, Columbus.

What Determines Compensability of Skin Dis-

ease Among Industrial Workers—Dr. Carey P. McCord, Cincinnati.

General Discussion.

2:30 P. M.

Round-table Discussion by Statisticians of Various Boards.

7:30 P. M.

Round-table Discussion by Delegates.

Reports of Convention Committees.

Election of Officers and Transaction of New Business.

Adjournment.

NEWS NOTES of OHIO

Cleveland—Dr. Oscar Eisinger is spending several months in Vienna.

Cleveland—Dr. C. F. Ulrich has returned after a year and a half in Vienna where he studied at the Psycho-analytic Clinic.

Youngstown—Dr. O. W. Haulman is recuperating from a recent illness by vacationing in northern Michigan.

Youngstown—The Mahoning County Medical Society has under consideration a plan for establishing a central office, full-time secretary, telephone exchange and credit rating system.

Caledonia—Dr. Milton Axthelm, a graduate of the College of Medicine, Ohio State University, in 1931, has opened offices here.

Columbus—Miss Charlotte White, younger daughter of Governor George White, and Dr. Frank E. Hamilton, Columbus, were united in marriage August 3 in a formal ceremony in the garden at the Governor's Mansion, Columbus.

College Corner—Dr. Fred F. Shepard, recently an intern at Bethesda Hospital, Cincinnati, has located here.

Lorain—Offices have been opened here by Dr. Gerald Krupp, who recently completed his internship at St. Mary's Hospital, St. Louis. He is a native of Lorain.

New Concord—Dr. Isaac Curtis, who recently completed his internship at the Ohio Valley Hospital, Wheeling, West Virginia, has opened offices here for general practice.

Cleveland—Dr. Torald Sollmann, dean of the School of Medicine, Western Reserve University, is vacationing in Europe. He was accompanied by his daughter, Miss Mary Sollmann.

Shreve—Dr. V. C. Ward has been taking post-graduate work at the Mayo Clinic, Rochester, Minnesota.

Toledo—Dr. Abel A. Applebaum, former resident physician at the University of Michigan Hospital and an assistant in medicine at Yale University, has opened offices here as an associate of Dr. L. A. Levison.

Wilmington—Dr. E. Dayton Peelle has completed his internship at the Hollywood Hospital, Hollywood, California, and has returned to Wilmington to become an associate of his uncle, Dr. F. A. Peelle.

Waynesburg—The Waynesburg Rotary Club was entertained recently by Dr. H. V. Weaver, Canton, who told of his trip to New Orleans to attend the annual session of the American Medical Association.

Fredericktown—Dr. O. W. Rapp is attending medical and surgical clinics at Johns Hopkins University.

Springfield—Dr. John Srail, formerly of Cleveland, has been named assistant to Dr. J. D. Thomas, superintendent of the Clark County Tuberculosis Sanatorium.

Toledo—Dr. R. A. Tank has returned after a six-weeks post-graduate course in obstetrics at the Lying-In Hospital, New York City.

Toledo—Dr. Martin Larkin was seriously wounded when he grappled with a bandit who commandeered his automobile while being chased by local police.

West Union—Dr. Robert B. Ellison, son of Dr. and Mrs. S. J. Ellison of West Union, who recently completed a year's internship at the Marine Hospital, New York City, is visiting his parents.

Cleveland—Dr. A. A. Jenkins was elected president of the Alumni Association of the School of Medicine, Western Reserve University.

Cleveland—Dr. H. J. Gerstenberger gave the annual address before the Case Chapter of Sigma Xi.

Cleveland—Dr. Howard Dittrick was awarded a gold locket and scroll for 25-years service as medical examiner for the Prudential Life Insurance Company.

Cleveland—Dr. and Mrs. R. R. Renner are spending several months abroad where Dr. Renner will take post-graduate work in surgery.

Cleveland—Dr. and Mrs. W. E. Shackleton have returned from a motor trip through the East.

Cleveland—Dr. H. J. John addressed the medical section of the American Life Insurance Company's annual meeting at West Baden, Indiana.

Cleveland—Dr. and Mrs. S. C. Lind have sailed for several months' tour of Germany and Russia.

Cincinnati—Dr. A. G. Beyer has been elected president and Dr. Samuel Seltz, secretary, of the Cincinnati Oto-Laryngologic Society.

Cincinnati—Dr. A. Graeme Mitchell addressed the annual meeting of the West Virginia State Medical Association at Parkersburg.

Petersburg—Dr. J. F. Dulick, formerly on the staff of the Youngstown City Hospital, has located here.

Conneaut—Offices for a joint practice have been opened here by Dr. C. T. Risley and Dr. G. A. Dye, both graduates of the College of Medicine, Ohio State University.

Toledo—Dr. Park W. Willis, chief resident physician at Flower Hospital, has returned from post-graduate study in Germany and France.

Port Clinton—Dr. Harley Lehnert, formerly on the staff of Flower Hospital, Toledo, has joined the staff of the Pool Hospital, here.

Mansfield—Dr. Howard Peck, formerly of Cleveland, has been named resident physician at the Mansfield General Hospital.

Toledo—Dr. Malcolm L. McInnes, formerly resident physician at Toledo Mercy Hospital, has begun private practice in the offices of the late Dr. George T. Hannah.

Toledo—Dr. Matthew Ginsburg, former resident pathologist at Toledo Hospital, has opened offices for private practice.

Carrollton—Dr. Carl A. Lincke, former intern at White Cross Hospital, Columbus, has opened offices here.

Dayton—Dr. Vernon C. Hart, professor of orthopedic surgery, University of Michigan, has resigned that position to accept the directorship of the new department of orthopedic surgery at the Dayton Clinic.

Toledo—A golf team of the Toledo Academy of Medicine defeated a team of Lima physicians at the Heather Downs Country Club, 41½ to 18½. Dr. Tom Heatley, Toledo, was medalist.

Readers of *The Journal* are again reminded of the series of post-graduate lectures which will be presented in Lima, September 26 to 30 by Dr. Julius Bauer, professor of medicine, University of Vienna, under the auspices of the Academy of Medicine of Lima and Allen County. The Lima Academy has invited any member of the profession who can do so, to arrange his vacation so as to spend that week in Lima and attend the lectures. Arrangements for the meetings are in charge of Dr. P. I. Tussing, 507 W. Spring Street, Lima.

The International Assembly of the Interstate Postgraduate Medical Association of North America will be held in the Murat Theatre and Shrine Temple, Indianapolis, Indiana, October 24-28, 1932. Many distinguished teachers and clinicians will appear on the program.

Deaths in Ohio

Francis William Alter, M.D., Toledo; Bellevue Hospital and Medical College, New York, 1896; aged 63; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died July 19 following a brief illness. Dr. Alter was a native of Toledo and received his early education there. He had always been active in medical organization, having held various offices in the Toledo Academy of Medicine during the past 30 years. Dr. Alter was on the staffs of St. Vincent's, Mercy and the Lucas County hospitals. He held memberships in the American College of Surgeons, and American Academy of Ophthalmology and Otolaryngology. Surviving are his widow, five sons, two daughters and two sisters.

Marcus Bradford Carleton, M.D., Wooster; New York University Medical College, 1881; aged 77; died of heart disease July 24 at the home of his son-in-law and daughter, Dr. and Mrs. R. R. McClellan, Xenia, where he had been visiting. Dr. Carleton had for many years been a medical missionary to India. He leaves his widow, two daughters and three sons, one of whom is Dr. Richard J. Carleton, Cleveland.

John M. Frick, M.D., Toledo; Rush Medical College, Chicago, 1902; aged 54; member of the Ohio State Medical Association and the American Medical Association; died July 13 of self-inflicted bullet wounds. Dr. Frick was a native of Ottawa. After finishing medical school he located in Toledo. During the World War, Dr. Frick was a first lieutenant in the medical corps. He was a member of the staff at St. Vincent's Hospital, and a member of the American Proctologic Society. Dr. Frick is survived by his widow, one son, his mother and two brothers.

Willis J. Kirkbride, M.D., Toledo; University of Michigan School of Medicine, 1901; aged 53; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died July 20 of appendicitis. Dr. Kirkbride had practiced in Toledo for the past 25 years, going there from Traverse City, Michigan. Surviving are his widow, two sons, three daughters, his father and two brothers.

Park M. Lchman, M.D., Ney; Starling Medical

College, Columbus, 1888; aged 74; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died July 9 of acute indigestion. Dr. Lehman had practiced in Ney for the past 39 years. The early years of his life were spent near Springfield. He is survived by his widow, one brother and one sister.

James H. Miller, M.D., Zanesville; Leonard Medical School, Raleigh, N. C., 1911; aged 60; former member of the Ohio State Medical Association and the American Medical Association; died July 27 of accidental drowning. Dr. Miller located in Zanesville 16 years ago. He was a member of the Colored Elks and Masons and of the Baptist church. Surviving are his widow and one sister.

John F. Shrontz, M.D., Martinsburg; Physio-Medical Institute, Cincinnati, 1877; aged 83; died July 26 of paralysis. Following graduation from medical school, Dr. Shrontz located in Newark and later moved to Knox County. He had practiced in Martinsburg for more than 50 years. He leaves two daughters and one son, Dr. W. E. Shrontz, Newark.

Leroy Pence, M.D., Lima; Medical College of Ohio, Cincinnati, 1882; aged 77; died July 10 following a 10-days illness. Dr. Pence practiced for many years in Spencerville before moving to Lima about 10 years ago. He is survived by his widow, two daughters, one son and three sisters.

Arthur Peter Smyth, M.D., Youngstown; University and Bellevue Hospital Medical College, New York, 1907; aged 49; mmeber of the Ohio State Medical Association and the American Medical Association; died July 10 of carcinoma.

John G. Spenzer, M.D., Cleveland; Western Reserve University School of Medicine, 1884; aged 68; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died July 26 following a brief illness. He is survived by his widow, one son and one daughter.

Henry C. Wendel, M.D., Cincinnati; Miami Medical College, Cincinnati, 1894; aged 63; former member of the Ohio State Medical Association and former Fellow of the American Medical Association; died July 24 of acute dilation of the heart. Dr. Wendel had practiced in Cincinnati since his graduation from medical school. Surviving are his widow, two daughters and one son, Dr. Carl H. Wendel, Cincinnati.

Joseph A. Windsor, M.D., New Richmond; aged 83; died July 24 following a long illness. He had practiced in New Richmond for the past 57 years. Surviving are two brothers and four sisters.

KNOWN IN NOHIO

Albert E. Bulson, M.D., Fort Wayne, Indiana; Rush Medical College, Chicago, 1891; aged 65: editor of the *Indiana Medical Journal;* Fellow of the American Medical Association and vice speaker of the House of Delegates of the A.M.A.; died July 17 of carcinoma.

Rose Jackson, M.D., St. Petersburg, Florida; Cleveland Pulte Medical College, 1899; aged 62; died July 6 after a lingering illness. Dr. Jackson was a former resident of Cleveland and Willoughby, moving to Florida about eight years ago.

Henry H. Peachey, M.D., New York; Medical College of Ohio, Cincinnati, 1889; aged 63; died July 19 at the home of his sister in Cincinnati. Dr. Peachey, a native of Cincinnati, had spent the past 30 years in South America where he was physician for a number of railroads and for exploring expeditions. He is survived by his widow.

Winthrop Randall, M.D., Mobile, Alabama; aged 85; died July 9. Dr. Randall practiced in Cleveland until 1922 when he moved to Mobile. He was a native of Lorain. He leaves one son and one daughter.

News Notes From County Societies and Academies

First District

Clinton County Medical Society held its regular meeting July 5 at Wilmington. Case reports were presented by Dr. Robert Conard, Dr. Kelley Hale and Dr. F. A. Peelle. The guest speaker was Dr. R. M. Hughey, Washington C. H., who spoke on "Differential Diagnosis of Iritis, Conjunctivitis and Glaucoma".—W. L. Regan, M.D., Secretary.

Highland County Medical Society met July 6 at the Colonial Inn, Hillsboro. Members of the Adams County Medical Society were guests. Dr. William Mithoefer of Cincinnati addressed the meeting on "Eye, Ear, Nose and Throat Problems".—News Clipping.

Third District

Hardin County Medical Society held a luncheon meeting July 12 at the Kenton Cafe. Speakers were Dr. E. O. Harvey, superintendent of the District Tuberculosis Sanatorium and Dr. C. F. Anderson, superintendent of the Ohio State Sanatorium, Mt. Vernon.—News Clipping.

Fifth District

Ashtabula County Medical Society held its annual joint outing with the Ashtabula County Dental Society at the Ashtabula Country Club, July

20. Wives of the members of both societies were guests. Following a golf tournament in the afternoon, dinner was served and the evening devoted to cards and games. The affair was in charge of Dr. P. J. Collander, president of the medical society; Dr. A. M. Mills, secretary, Dr. W. F. Gessler, Dr. Bernice Fleck and Dr. J. F. Docherty. News Clipping.

Geauga County Medical Society met in regular session July 27 at Chardon. Dr. W. E. Allyn addressed the society on "Influenza and Its Complications".—News Clipping.

Sixth District

Mahoning County Medical Society held its annual golf outing July 28 at the Squaw Creek Country Club. Dinner was served in the evening. —News Clipping.

Wayne County Medical Society met July 12 at Wooster with the largest attendance of the year. The program was interesting and enlightening. Dr. John J. Kinney presented a scientific paper on "Food for Thought", giving a review of the span between the protoplasm and the highest form of animal life. Dr. Fred Snyder gave answers to and commented on the first five questions asked by the State Medical Board at the June examinations. Dr. F. C. Ganyard answered the next five questions. The remarks provoked such an interesting discussion that it was suggested the remaining questions of the list be discussed at a future meeting of the society. Dr. G. S. Cunningham, a medical missionary to the Philippines, home on furlough, spoke on public health problems in the Islands and what has been accomplished under United States control. Dr. W. H. Lehman, a medical missionary to Cameroon, Africa, also addressed the society, describing some of the diseases and medical problems in that country.—R. C. Paul, M.D., Secretary.

Seventh District

Tuscarawas County Medical Society was addressed by Dr. E. B. Pierce, superintendent of the Molly Stark Sanatorium, Canton, at its meeting on July 14 at New Philadelphia. Dr. Pierce spoke on "Recent Advances in Diagnosis and Treatment of Tuberculosis." The talk was illustrated with films and slides.—Bulletin.

Eighth District

Guernsey County Medical Society was entertained at a chicken dinner July 7 by Dr. George F. Swan and the nurses of the Swan Hospital, Cambridge. The dinner, at which wives of the members were guests, was served in the nurses' home. Sixty were present. An impromptu program was presented after the dinner, with Dr. M. S. Lawrence, president of the society, acting as toastmaster. Short talks were made by Dr. Swan, Dr. Lawrence, Miss Mary Stone and Harry W. Amos. The American Legion Quartet sang. Prizes in a guessing contest were awarded to Dr. and Mrs. C. A. Craig and Dr. Gordon Lawyer.—News Clipping.

Perry County Medical Society met in regular session July 18 at the Park Hotel, New Lexington. Dr. James H. Warren, Columbus, was the principal speaker, talking on "The Importance of Diet in the Medical Profession".—News Clipping.

Tenth District

Madison County Medical Society at its regular meeting held July 27 at the London Country Club was addressed by Dr. J. W. Wilce, Columbus, on "The Heart and Sport".—News Clipping.

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HOSPITAL NOTES

—A schedule of all-inclusive, flat-rate charges applying to five divisions of hospital service, has been placed in effect at the University Hospitals Group, Cleveland, including Lakeside, Babies' and Children's and Rainbow Hospital for Crippled Children. The new flat rates include room, board, regular nursing service, operating room service, laboratory service, *X*-ray service and formulatory drugs; and applies to the divisions of medicine and pediatrics, surgery and obstetrics, tonsil and adenoid service, cystoscopic examinations and diagnostic service. The flat rates for surgical, obstetrical, medical and pediatric services will be available only when the patient remains six days or longer in the hospital. The diagnostic service is on a 72-hour basis and the remaining services on a 24-hour basis.

The rates under the schedule are:

Surgical and obstetrical (six-days service)—Open division bed, $47.50; semi-private bed, $62.50; private room, $85; special private room, $100. (A step-up in charges is made for additional days of service.)

Medical and pediatric service—Deduction of $20 from the above rates.

Tonsil and adenoid service (24-hour service)—Open division, $13.75; semi-private, $16.25; private, $20; special private, $22.50. (Deduction of $5 if local anesthetic is given).

Cystoscopic (24-hour service)—Open division, $13.75; semi-private, $16.25; private, $20; special private, $22.50. (Deduct $5 for examination without pyelogram).

Diagnostic service (72-hour service)—Open division, $31.25; semi-private, $38.75; private, $50; special private, $57.50.

—The second anniversary of the opening of Swan Hospital, Cambridge, under its present management was celebrated recently with a dinner party.

—The following have been named interns at Miami Valley Hospital, Dayton:

Dr. George P. Bohlender, Ohio State; Dr. Howard R. Campbell, Ohio State; Dr. Robert E. Boswell, George Washington; Dr. Lloyd Bonar, Mansfield, University of Cincinnati; Dr. Eugene Damstra, Holland, Mich., Northwestern university; Dr. Richard M. Free, Bethlehem, Pa., Hahnemann Medical college; Dr. H. Worley Kendell, Covington, O., University of Cincinnati; Dr. Orville L. Layman, Germantown, Ohio State; Dr. Tom L. Lewis, Columbus, Ohio State; Dr. Earl C. Leyrer, Hamilton, Hahnemann Medical college; Dr. Ralph H. Miller, Cincinnati, University of Cincinnati, and Dr. W. W. Webb, East Ely, Nev., Northwestern university.

—Under the will of the late Miss Emma Chance, the Hillsboro Hospital in the residuary legatee of her entire estate amounting to $20,000.

—The following have been appointed to the medical staff of Christ Hospital, Cincinnati: Attending pediatrics, Dr. B. Hoyer and Dr. Harold T. Downing; attending obstetrics, Dr. James Pierce; junior obstetrics, Dr. William Gillespie; junior medicine, Dr. Irving Schroth and Dr. O. J. Baumes; junior ophthalmology, Dr. Albert Brown; attending medicine, Dr. H. H. Shook and Dr. W. O. Ramey; attending otolaryngology, Dr. Ben L. Bryant and Dr. H. H. Haggart; attending gynecology, Dr. V. B. Roberts.

—The following interns and resident physicians have been appointed for the Lucas County Hospital:

Dr. Earl W. Bailey, Dr. Jean A. Nock, University of Cincinnati; Dr. Charles A. Carroll, University of Iowa; Dr. William W. Lanou, Dr. Reid P. Joyce, University of Pennsylvania; Dr. C. Ray Markwood, Dr. Orval J. Miller, Dr. William Vinvent Stephenson, Ohio State university; Dr. Alexander Robertson, University of Michigan; Dr. Herbert L. Sedam, Indiana university. Resident physicians—Dr. Burgess E. Demuth, Ohio State; Dr. Walter F. Galbreath, Dr. George R. Hazel, both of the Indiana university, and Dr. Boyd W. Travis, University of Pennsylvania.

—Dr. Herbert A. Mahrer, head of the *X*-ray department of Mt. Sinai Hospital, Cleveland, has been appointed *X*-ray consultant for Elyria Memorial Hospital.

—A gift of $1,000 was made to Providence Hospital, Sandusky, by the Women's Association of the Hospital.

—After serving 13 years as chief of staff at the Findlay Home and Hospital, Dr. J. C. Tritch has tendered his resignation to the executive board of the institution. The resignation was accepted with regret by the board which appointed Dr. J. M. Firmin as Dr. Tritch's successor. Before the hospital staff was organized on its present basis, in 1919, Dr. Tritch served the institution as chief physician for a number of years.

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PUBLIC HEALTH NOTES

Thirteenth Annual Conference of Health Commissioners with the State Department of Health will be held Wednesday, Thursday and Friday, November 16, 17 and 18 at the Deshler-Wallick Hotel, Columbus, Dr. H. G. Southard, director of the department, has announced. The program for the meeting is now being drafted and will be published in *The Journal* when available.

—Two score health commissioners, nurses and health department employes from the 17 counties comprising the Central District of the Ohio Federation of Official Health Workers attended the annual conference of the district on July 28 at the Elks' Home, Lancaster. The program was arranged by Dr. O. M. Kramer, health commissioner of Fairfield County. Among the speakers were: Mayor R. U. Hastings, Lancaster; Dr. H. G. Southard, state director of health; Dr. E. R. Shaffer, chief of the Division of Health Organization, State Department of Health, and secretary of the Ohio Federation of Official Health Workers; Dr. B. F. Neiswander, health commissioner of Franklin County; Dr. O. D. Tatje, health commissioner of Portsmouth, and Dr. E. R. Hayhurst, consultant in industrial hygiene, State Department of Health.

—Five counties in Ohio, general health districts heretofore provided with adequate whole-time health service which owing to economic conditions was tending rapidly toward abridged part-time service, will receive sufficient aid to enable them to approximate the accustomed scope of their health work under an apportionment of Federal and International Health Board funds of which Dr. H. G. Southard, State Director of Health has been advised. The counties are Hocking, Fayette, Medina, Shelby and Richland. The money is available as of July 1, 1932.

The whole purpose of the grant is to aid counties which have had good public health service but which, owing to economic stress, are no longer able to carry on as heretofore. Dr. Southard made the initial contacts last winter when he was in Washington to attend the Surgeon-General's Conference of State and Provincial Health Commissioners. He obtained tentative promise of a grant from the Rural Health Section of the U. S. Public Health Service and a supplementary grant from the International Health Board of the Rockefeller Foundation. The plan was shaped up through subsequent correspondence and, finally, there was a joint apportionment of $8500 for the work.

Each of the five health districts will be able to maintain at least one nurse out of its portion of the grant, and in some of them other benefits will be derived that will enable them to maintain their former high standards of public health work.

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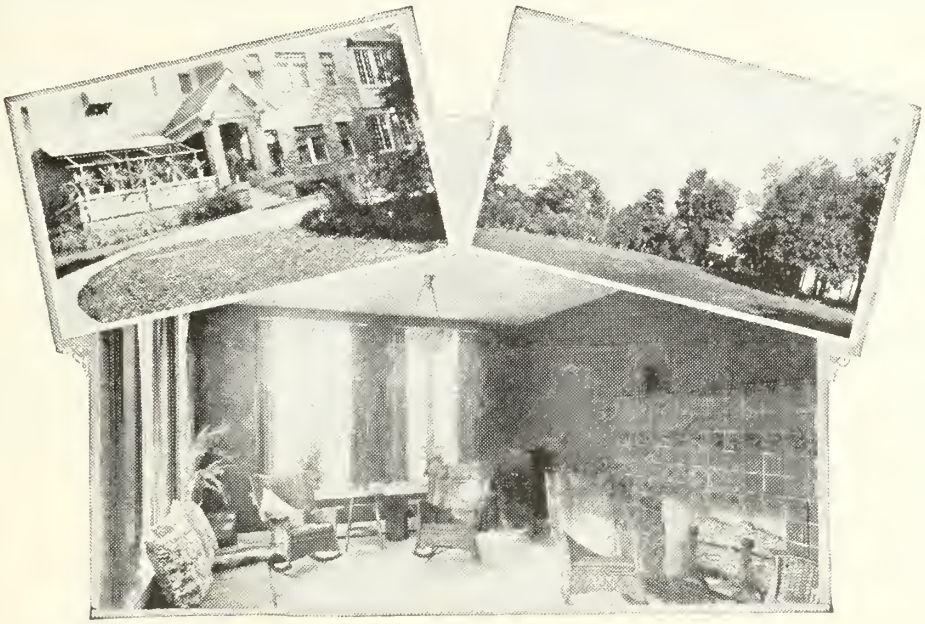
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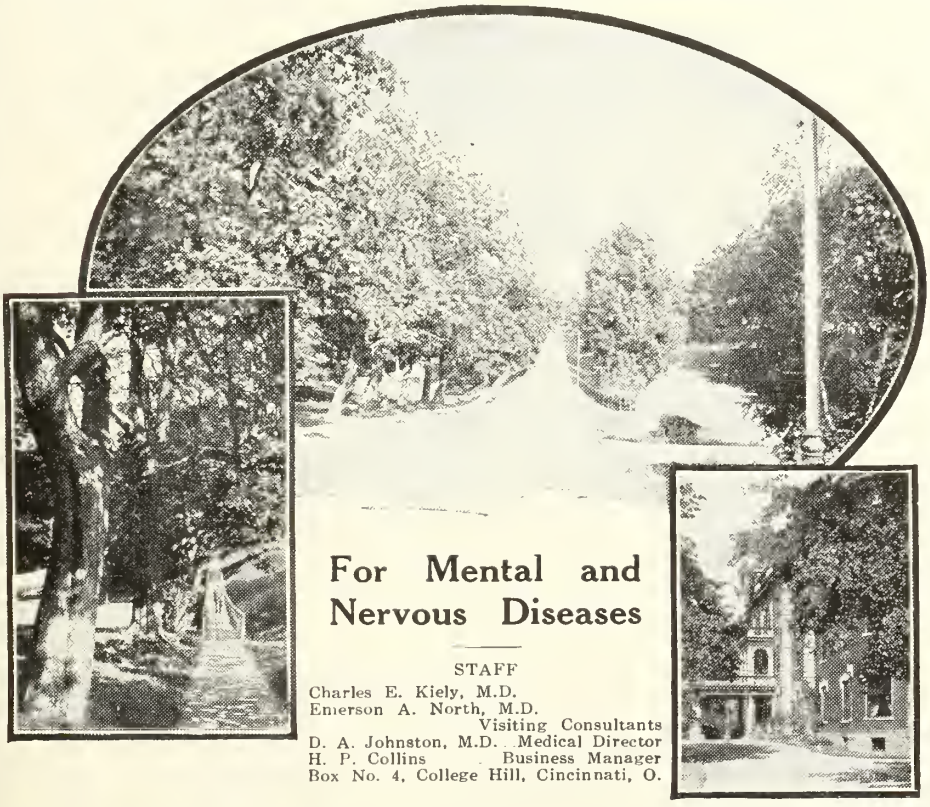
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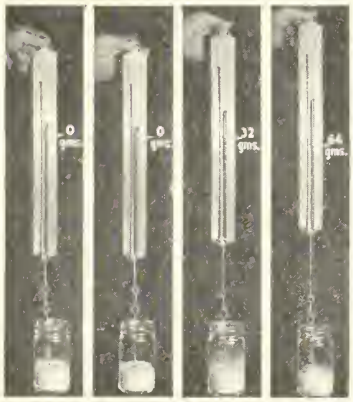
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[1] London & Polowzowa: Zeitschr. f. physiol. Chem. 1906, XLIX, 328.

[2] Marriott: Infant Nutrition, pg. 81.

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PUBLIC HEALTH — SOCIAL WELFARE MEDICAL ECONOMICS and ORGANIZATION PROBLEMS

With Editorial Comment by D.K.M.

In a little more than a month—on November 8—the electorate of Ohio will go to the polls to cast their votes for candidates for local, state and national public offices.

On Taking Part In Public Affairs

Not since the period immediately following the Civil War, in the opinion of many political observers, has there been a general election of such vital importance. This year as never before there must be no shirking of responsibility on the part of the voters. Discriminating and clear-headed thinking must prevail.

Unfortunately, many factors arising from the current period of unrest and unsettled business have been cast into the political arena, greatly confusing the public and giving the demagogue a chance to toot his horn.

This undoubtedly, has been a development from the popular, but fallacious, idea that government can solve all problems and settle all questions.

As Merle Thorpe points out in his concise and direct way:

"Government is no longer the simple affair of our forefathers. To it we ascribe superhuman and supernatural powers, forgetting it is only a cross-section of the citizenry of the country, with all the ambitions, inhibitions, vices and virtues of the rest of us. Yet we solemnly propose through this growing and gangling organization called government to make and unmake economic laws, to impose on intelligence and industry increasing penalties, the while coddling and condoning idleness and folly. For our recourse to a political administration of all our affairs we are paying a price. Today governmental overhead has reached 30 per cent—fifteen billions out of a total national income of fifty to fifty-five billions, with between eighteen and twenty millions of our people dependent upon tax payrolls. We pay another price, the price of economic freedom. * * * During the coming months, candidates will promise relief for this and that through law, or regulation, or outright dole. Each proposal will call for additional administration and expense. To all such the voter should reply as did the French philosopher: 'That government is best which paves the way for its own resignation'. In other words, the candidate who promises 'to govern least' will get my vote."

Because government is "no longer the simple affair of our forefathers" and because government promises to play a leading part in the coming period of readjustment and reconstruction—whether it should or shouldn't being just now beside the point—the approaching November election becomes of supreme importance.

Unless the public elects the right kind of officials to handle the affairs of government—local, state or national—it may expect rapid growth in the bureaucratic, paternalistic and socialistic activities of government.

Physicians can, and should, play an active role in the campaign leading up to the November election. As emphasized time and again to the membership of the State Association, physicians as individual citizens and as a professional group whose primary interest is in the welfare of the public have a right to take a keen interest in the type of men and women running for public office, as well as in the administration of governmental matters and in the kind of legislation being proposed, especially on those subjects in which the medical profession is vitally interested, and best informed.

"The Doctor's Vote Still Needed" is the caption which appeared over an editorial published in a contemporary state medical journal, which urged the physicians of that state to support at the polls candidates who have the correct attitude on health and medical questions.

The doctor's vote will be needed in Ohio in November, and needed badly. However, that is only one phase of the obligation which the physician owes to the public and to himself. He must lend his active cooperation and support to the candidacies of those whom he knows are appreciative of the benefits of scientific medicine, believe in safe and sane public health safeguards; have the best interests of the public at heart; are qualified both in ability and character for the offices they seek; and are willing to look to the medical profession for advice and counsel on matters pertaining to scientific medicine, public health and social-economic questions affecting medical practice and the economic status of the physician.

Of course, it should be borne in mind that medical organization, as such, is *not*, and should not be, political. It should not officially endorse or oppose individual candidates. It must hold aloof from partisan issues. But physicians as leading and responsible citizens should participate as in-

dividuals in political affairs. It is especially important that physicians inform themselves of the attitude and qualifications of candidates and that they give their individual influence and support to those candidates whom they are sure will be willing to lend an attentive ear to the sound medical viewpoint on public health and medical questions.

The Lessons of Adversity

Business and professional groups are beginning to take inventory of some of the immediate and probable future effects of the prolonged period of unrest and business depression. The medical profession should do likewise.

Many physicians have had their life-time savings destroyed. All have seen their professional incomes decrease many fold. The profession as a whole has witnessed the growth of radical schemes and programs which threaten to throttle individual, competitive medical practice.

This is one side of the picture. There is another. It is a bit more cheerful, although it is not quite so obvious to the physician who has had his hands full trying to make a living for himself and his family.

However, there have been a few developments during the past two years which promise in the final analysis to prove of some benefit to the medical profession.

Dr. A. W. Thomas, Youngstown, enumerated a few of them in the August, 1932, issue of the *Mahoning County Medical Society Bulletin* in an editorial in which he made an interesting and accurate analysis of the present situation from the standpoint of the medical profession.

"If there can come any satisfaction from a survey of the business situation of the past two years," Dr. Thomas writes, "we may appreciate it in a reflection upon the reaction of the practicing physician to this emergency.

"The members of our profession have met this epic with a stoicism and with a failure to give up courage, and while there have been and still will be many dark days, few of our number have actually given up in despair, and mental collapse has been very rare.

"In normal financial times, a practitioner of ten years' experience has become so used to accepting responsibility in the diagnosis and treatment of serious problems that he probably adopted the mental attitude of assuming the depression as just one more burden, but one which he was strong enough to carry and which he would carry without complaint. This sort of attitude has brought him to the present and most certainly will carry him through to better times.

"I am sure that, quietly, the physician has made a valuable contribution by spreading a word of courage and of cheer, as he made his rounds, to those of his clients who were in desperate circumstance, and very often he has gone down into an almost depleted pocketbook to buy food for the starving. Word has come to me of numerous instances of this kind, but the donors would blush to acknowledge having performed these services.

"The standards of medical practice have not been lowered, indeed the opposite is true. Fees have, in many instances, been trimmed to meet the ability of the client to pay, extended credit has been allowed those who deserved it, and there has been no "cut-rate" practice which has come to the attention of the organized profession in this county. Upon several occasions the influence of the Mahoning County Medical Society has been used for community benefit and there is much reason to feel that we have obtained a certain "standing" and recognition amongst the other civic groups; and that our advice will be sought more and more frequently upon health matters as we continue to develop.

"It occurs to me that our plans for the future should include a very strict definition as to what *is* and what *is not* charity. We should assume that the destitute and the poor are not our responsibility but that they should be provided with such medical care as they need from tax funds as are the schools, the parks, the streets and all other city and county projects. We should be mindful of the enthusiasm of social-service groups and should carefully analyze the need for free clinics, and where we are sure that charity is being abused, we should withdraw from these places such of our members who may be there employed. Charity should be forced upon no person and, as it is usually the medical profession which is called upon to actually donate of its time and experience, we should be privileged to assure ourselves that the effort is not misdirected.

"We have had sufficient courage to carry us through troublous times. Let us have courage to carry us through normal times."

The past two years have, as Dr. Thomas points out, been an acid test of the character and courage of the average physician. The fact that so few have broken under the strain lends hope and encouragement to the future. The medical profession should by this time have added confidence in its courage and ability to meet and solve extraordinary problems and situations. This confidence will mean much in the future.

Moreover, the fact that there has been no apparent lowering of the standards of medical practice and in general a close adherence to the ethics and principles of the profession, speaks well for the members of the profession; likewise, for the principles themselves.

The past two years, furthermore, has demonstrated in a forceful way the value of medical organization. Without strong, active and united medical organization, the profession would have had a much tougher time than it has had. Standing alone, it is doubtful if some individual physi-

cians would have been able to pull through the depression at all.

Much which the profession has learned during the past two years will prove useful in facing the problems of the future, some of which are as vital, if not more so, than those of the past. In some respects, the profession should come out of the depression better prepared and stronger than it was before. The profession has learned many valuable lessons from the experiences of the present period, the same as all other business and professional groups. This will make the future clearer. It should make it more secure.

Malpractice Responsibility

Since every physician constantly is confronted with matters involving and concerning medico-legal matters and with factors incidental to threats and suits for alleged malpractice, it is to his advantage to know as much as possible concerning the rights and privileges which he possesses under the law and the legal technicalities of medical malpractice.

Naturally, the physician who is well versed on legal principles governing medical practice and has a fair knowledge of factors and situations which have caused the filing of malpractice suits against other members of the medical profession, is better fortified to avoid threats and suits than the physician who has given little or no thought to these questions.

The Journal has constantly endeavored to keep members of the State Association adequately informed on the question of medical malpractice and for years the annual report of the Committee on Medical Defense has been full of splendid suggestions and advice on these matters.

However, for the sake of emphasis, the following explanation of the physician's liability and responsibilities in connection with medical malpractice is quoted from a recent article by Dr. I. S. Trostler, Chicago, published in a contemporary journal. Dr. Trostler's conclusions are based on legal interpretations and court decisions from all sections of the country. While his conclusions may not apply to all cases, in general they offer valuable suggestions for the physician.

Quoting from his article:

"A physician or surgeon may be adjudged liable for malpractice when bad or injurious results follow as the effect of his ignorance or neglect; when he makes use of unusual methods or practices, or when he fails to use methods or means which are customarily applied in his or similar localities.

"He may be held liable for bad or injurious results which may depend upon his lack of skill or knowledge, if it can be shown that he should have possessed that skill and knowledge.

"He may be held liable if he fails to exercise the degree of care and diligence which is customary in his locality and under similar conditions.

"Lack of payment or remuneration for his services does not relieve nor release him from assuming the same responsibility and liability, as if he were being paid a large fee.

"He is responsible for the acts of his employes, agents and assistants.

"He may not be held liable for honest errors of judgment, particularly in difficult, complicated and uncertain cases.

"He may not be held liable if he acknowledged that he lacked sufficient skill or knowledge to properly treat or diagnose the case in hand, before undertaking or assuming same.

"He is not required, nor is he expected, to guarantee or insure a cure or beneficial results from his attendance on any case of illness, injury or disease.

"A physician or surgeon may not be compelled to undertake or assume the care of a patient, unless he so desires; but, after having undertaken or assuming such care, he cannot withdraw except under certain conditions and with the knowledge of the patient (or those responsible for the patient).

"He cannot be adjudged liable for malpractice after he has won a law-suit for the fees for his services in the same case under certain conditions.

"He is relieved from responsibility and liability if the patient has directly contributed to the negligence charged in the case."

Itemized Statements

These being days when more business-like tactics are being pursued in all lines in an effort to make both ends of the business or family budget meet, physicians should not overlook any reasonable suggestions relative to ways and means of minimizing bad accounts and of stimulating collections.

The statement frequently made that physicians are bad business men is grossly exaggerated. Many physicians are careful in their business dealings and maintain accurate bookkeeping systems, as well as effective methods for the collection of accounts. However, there is always room for improvement no matter how efficient and effective the office system used.

One of the frequent criticisms voiced of the medical profession in this respect is that physicians do not itemize the statements sent to patients for services rendered. This may seem to the physician a small matter but to many patients it is regarded an important item, and occasionally causes unnecessary ill feeling between the physician and his clientele.

Regarding this particular question, the Bulletin of the Wayne County Medical Society (Detroit) editorially offers the following advice:

"Bills that are not itemized often create resent-

ment in the minds of patients and frequently raise the question as to the validity of the charges made for services. These two factors mitigate against prompt payment of the account in question and are responsible in no small measure for disagreements between patient and doctor.

"The average debtor is interested in having placed before him an itemized account so that he may have the opportunity not only of checking the individual items for which he is being charged, but of adding the sums involved to make sure that no mistake has been made. Since he is the one who is asked to foot the bill, he feels that he has the right to know just what items he is charged with and how much he is paying for each of them. On receiving a bill which denies him this privilege his first reaction is to delay payment until the explanaton that he feels is his due, has been made. Almost invariably, a lump sum looks bigger than the same figure arrived at by the addition of a number of smaller charges and is likely to create an undesirable impression of exorbitance.

"The common practice among doctors to send out unitemized statements may be responsible for the feeling that doctors' bills come high, and may be one of the reasons behind the general tardiness in the payment of those bills.

"Those physicians who have changed to the more businesslike method of itemizing their accounts report a decrease in disagreements with patients, and a gratifying increase in collections.

"There is no good reason why the medical profession should not adopt, for the business side of its practice, those tried methods which business in general has found valuable. If so simple a procedure as itemizing our bills promises to eliminate dissatisfaction and speed up payment, then by all means let us all adopt the method and put it into use at once."

A Socialized Lesson as Taught By France

American advocates of extreme social legislation undoubtedly are scratching their heads over recent developments in France, the best known recent convert of the theory of paternalism on a nation-wide basis.

According to a recent United Press dispatch from Paris, France's compulsory insurance law, which compels all workers whose annual salary does not exceed $600 to contribute to a national insurance fund for financing everything from unemployment to health and medical services, is meeting with growing unpopularity, and there has arisen a concerted movement for repeal of the legislation which has been in force a little over a year.

"Theoretically, the scheme sounded ideal to the political groups of the left and they forced its passage through Parliament," the United Press correspondent wrote.

"Practically, the scheme has not worked out so well. Many laborers refused to contribute and asked for five per cent wage increases so that the insurance payments would not come from their wage envelopes. That brought an immediate reaction in living costs. Workers who were injured and sought to collect insurance on their claims found that they had run into endless red tape."

Another slant on the present situation in France is revealed in another article from Paris carried in the American press, in which the trials and tribulations of the Socialist leaders who forced the social insurance law onto the country are described.

Commenting on the average Frenchman's political views, one correspondent declared that the Frenchman "votes Red only so long as it does not affect the pocketbook".

"The economic crisis has revealed to the world that the average Frenchman remains unchanged —a man of small needs, toiling and saving all his life to satisfy those needs," it is pointed out.

"Which explains why he can become banker to Europe.

"At the moment the bankrupt condition of those nations which have been experimenting with Socialistic legislation appeals to the pocketbook of the Frenchman much more than to his mind. He has come to the realization that such legislation is a menace to his savings and property. Leon Blum and other Socialist leaders, most of them men of substance, may reiterate that the doctrines are sound enough but have not been applied to the full. The average Frenchman listens, says nothing—and goes home to change the hiding place of his savings."

Still another lesson to be learned from happenings in France is outlined in a report of a Committee on Study of Dental Practice of the American Dental Association.

This report points out how the medical and dental professions joined hands to have written into the present state insurance law in France certain provisions that called for complete freedom of choice of practitioner by claimants; the direct payment of fees; professional representation on all administrative bodies; the safeguarding of professional secrecy; no lay control of professional activities, etc.

As a result of the victory of these professions, the report states, some of the insurance societies have "struck" and refused to sign the uniform contracts presented by the medical and dental professions in accordance with the law, and are beseeching the politicians to amend the law to take away some of the advantages gained by the physicians and dentists.

So, it would seem that all does not go well with France's experiment in extreme social insurance.

For France to follow the stormy path taken by Germany, England, and other neighboring countries who have suffered because of their venture into fallacious social insurance schemes, was thoughtless, to say the least.

Should America with the examples set by Germany, England, and now France, staring it in the face, adopt socialistic or communistic programs?

The Problem of Hypersusceptibility in Eczema and Dermatitis: Its Relation to Internal Medicine

H. N. Cole, M.D., Cleveland, Ohio

ECZEMA is a term very old in medicine and was originally looked upon as a condition generally due to the effects of irritation and was usually considered to be of internal origin. Originally it covered a multitude of dermatological entities that have since been studied and eliminated from the group heading of eczema. For example, there have been separated the mycotic infections of the skin, scabies, the streptococcus infections of the skin, impetigo and ecthyma, seborrheic dermatitis and diphtheria of the skin. Despite the withdrawal of these distinct dermatological conditions, we still find that there is some confusion in regard to eczema, and especially in its relation to dermatitis. In America, at least, there seems to be a tendency to consider any process on the skin in the form of a known irritation as a dermatitis; for example, the person susceptible to the Chinese primrose, who develops an eruption on the exposed parts of the body after contact with the primrose. This is usually spoken of as a dermatitis.

On the other hand, those types of inflammatory reaction on the skin, where we are unable to find any external cause, and, in fact, where we are unable to find even an internal cause, are looked upon as an eczema. Thus the eruption on the skin that is occasionally seen in connection with diabetes, we would not speak of as an eczema diabeticorum, even though it is of internal origin, but rather as dermatitis diabeticorum, because the cause is known. If, however, we have a patient with a pruritic, inflammatory eruption, for example, on the palms of the hands, perhaps of long duration, causing thickening of the skin, cracking, scaling and exudation, and if, in such a patient, we are unable to find the cause or to diagnose it, the American dermatologist would classify this as an eczema.

Given a case such as I have described, if we are unable to find any external causation for it, are we justified in terming it an eczema, and could we, perhaps, by careful study of the internal workings of the body, find some explanation for it? Would we, for example, be able to find any metabolic disturbances in a case of this sort? The Swiss dermatologist Bloch says: "There is a complete failure in showing the existence of metabolic disturbances which are common to all, or to many, types of eczema, and which are pathognomonic for this condition of the skin. Viewed from the standpoint of physiological chemistry, eczema is not a metabolic disease." Nevertheless, we find a large group of dermatologists, not only American, but also English, and a few French, notably Sabouraud, who are convinced that typical cases of idiopathic or endogenous eczema do exist and that they exhibit certain peculiarities and clinical differences by which they can easily be distinguished from their occupational prototypes, as, for example, dermatitis from a Chinese primrose.

Read before the Medical Section, Ohio State Medical Association, at the 86th Annual Meeting, Dayton, May 3-4, 1932.

From the Department of Dermatology and Syphilology of the Western Reserve University Medical School, and the Cleveland City and Lakeside Hospitals.

ETIOLOGY OF ECZEMA DERMATITIS

What, then, is the etiology of these conditions? Do they have any definite basis of causation? We know that certain sufferers from eczema are also troubled with asthma and hay fever. Cases are reported of hay fever and concomitant eczema secondary to the ragweed. We are all acquainted with patients who, for example, after the ingestion of quinine or buckwheat, suffer, not only from an eruption on the skin, but also from asthmatic symptoms. Such a patient, we would speak of as idiosyncratic to buckwheat or quinine, and we find this idea of idosyncrasy increasing in favor as a factor in the causation of eczema. Thus the English dermatologist Barber would define eczema as "An inflammatory reaction of the skin indicative of epidermal sensitization", and the Swiss dermatologist Bloch defines eczema as an "Idiosyncratic disease of the skin".

We all are acquainted with the patient who gets a violent reaction after the application of adhesive plaster to the skin. We might say that this patient is idiosyncratic to adhesive plaster, inasmuch as a normal person may have it applied and show no reaction. Or we may use the term hypersensitive to the adhesive plaster. There is some preparation in this adhesive plaster to which the patient is hypersensitive. We speak of this as a hypersusceptibility. The normal individual will not react to it. On the other hand, the hypersensitive individual may react to even a small amount of the adhesive plaster, an amount that in a normal individual would cause no reaction of the skin in the least.

Another term that is used for this hypersensitive state, or this state of hypersusceptibility, is allergy. It simply means an altered state. The doctor who gets a dermatitis of the skin after putting his hands in a bichloride solution is in a state of allergy to bichloride. He is hypersusceptible to the bichloride. To give an example, we recently saw a patient in our clinic with a dermatitis localized along the one temple and running back over one ear. The process was

sharply localized. The patient was wearing horn rimmed spectacles and told us that he had been wearing them for years. On close questioning, however, we found that two weeks before one of the arms of the spectacles was broken and he had bought another one to replace it. We examined this new arm, which seemed to be of a somewhat different material than the original spectacles and took a scraping from the material and applied it to a spot on the patient's arm, leaving it there for 24 hours. The patient reacted with a very extensive edematous and vesiculating reddish reaction over the area where the scraping was applied. In other words, there was some preparation in this new arm to which the patient was hypersensitive; he showed a hypersusceptibility to it. Hence, he was in an allergic state to these scrapings.

Much work on the idea of allergy, of hypersensitiveness and of hypersusceptibility has been done, both in this country and abroad. It seems to have started with the so-called skin tests that were so popular in America some years ago. They then for a time fell more or less into disrepute, inasmuch as the results were so often inconclusive. The Germans have since taken them up in a very enthusiastic manner and have further elaborated them.

In addition to these intradermal tests, they are also employing another type of test known as the patch test. I have already indicated the technic employed. The suspected irritating agent is placed on a clean piece of old linen about one inch square. If it is dry it may be moistened with a little water in order to make it adhere better to the linen. This is then applied to the skin of the arm and a larger piece of linen is placed over this and kept in place by means of adhesive plaster for a period of 24 hours. Instead of linen as a covering material one may also use cellophane. If the patient is susceptible to this suspected agent he will react with a certain amount of signs of inflammation locally, for example, simply an erythema; or, if he is very susceptible, he may even have a vesicular reaction; or, if he is most susceptible, he may even have a reaction going on to necrosis. Occasionally we get what is known as a relayed reaction after these so-called patch tests, the reaction not showing up for 48 hours, and in certain cases, it may not show up for even 10 or 12 days. As a rule the skin is not rubbed as a preliminary in making the test. If a strong acid or alkali is suspected as being the cause of the trouble it will be necessary to dilute it. In certain clinics today this test is used so widely that they have certain stock preparations used on every case of eczema or dermatitis presenting itself at the clinic.

In Prof. Bloch's clinic at Zurich, Switzerland, they use turpentine, quinin-hydrochlorid, formaldehyd (1 to 5 per cent), tincture of arnica, bichlorid (1 per cent), iodoform, white precipitate ointment, extract of Chinese primrose, adhesive plaster, mercury plaster and naphthalene. In addition, they also make patch tests with all preparations with which the patient comes in contact. For example, we recently saw a boy sent to us by a large printing establishment down in the state. He had an extensive, crusted and vesicular dermatitis of the hands, the process extending up the arms as well. He also showed a patch of dermatitis over the anterior surface of both thighs. There was also a certain amount of reaction over his face and ears. He explained to us that he was a printer and that his work caused him to carry trays of the type from table to table and that in doing so he sometimes noticed a certain amount of moisture over the front of his trousers, especially where they came in contact with these trays loaded with the washed type. We inquired as to the materials used in the washing of the type and he told us that recently, because of complaints from the workmen, they had changed and were now using a new type of washing material that was claimed to cause no irritation of the skin. We had the patient bring up some of the type metal ground up and also some of the material used in washing the type. A patch test of powdered type metal gave a negative result. The area on which the solution used for washing type was placed reacted in the space of 24 hours, with a very violent explosive vesicular dermatitis. Thus the cause of the boy's dermatitis was discovered. He was advised to stay away from his work for a week or so until the process cleared. The washing material for the type was changed in the factory and the boy has had no further trouble. We have since found that the material used was simply a cheap form of gasoline. This preparation that did not irritate most of the workmen caused a severe dermatitis in his case. He was hypersusceptible to this washing fluid.

Let us take another example: A young man came to our clinic with almost a generalized, erythematous, scaly eruption. The diagnosis of dermatitis exfoliativa was even considered. He explained to us that he had had a mild eruption on the hands and had gone to a druggist, who mixed up an ointment containing several preparations and gave it to him. His skin had been violently irritated after its use. After the patient's skin had become sufficiently healed we made several patch tests, using sulphur, zinc oxid and white precipitate respectively. He developed a confluent dermatitis of the entire arm from the patch test made with the last named article. He was hypersensitive to white precipitate.

We see certain cases that have a hypersusceptibility to but one substance, as in this last case. We speak of this as monovalent. Again, we may find an individual that is susceptible to more than one irritating substance. In such a case we would speak of it as a polyvalent hyper-

susceptibility. Rarely we may encounter a case that may be susceptible to all the test preparations that we mentioned as being used in one clinic. Bloch says that the average normal individual will not react to any one of the tests that they ordinarily use in their clinic; an isolated person here and there may react to one of them. As we get into the list of persons with a dermatitis, however, the per cent reacting rises very much. For example, it may rise to 25 or 45 per cent, and if, instead of using the routine stock articles for testing the skin, articles used in the person's trade and daily life are employed, we may find it increased even more.

In this greater reaction tendency of the skin we have the mean and essential difference between an eczematous and a non-eczematous individual. The eczematous individual has a latent idosyncrasy to various substances. His level of reaction is much higher than that of the normal individual. For purpose of comparison, let us suppose that in 100 normal individuals, 95 of them will not have any reaction to the test preparations that we have mentioned, while, on the other hand, if we get into the individuals suffering from dermatitis we may find that perhaps 50 of them will have reactions; or, again, it may even drop down to a place where but 20 of them have no reaction. The level of reaction in the eczematous individual is much higher than it is in a normal person, and what would not affect a normal person may cause a very violent dermatitis in one of these susceptible cases. Moreover, the factor of repetition comes in. It may be that even one of these susceptible persons will not have a reaction on his skin if he comes in contact with a certain substance only a few times, but if it is repeated day after day, sooner or later he will develop a dermatitis or an eczema of the skin.

DIAGNOSIS

What are the things that will assist us in making a diagnosis in one of these cases? We are dealing with an eruption showing redness, scaling, cracking, exudation, crusting and more or less thickening of the tissues, depending, of course, on the duration of the trouble. The process is usually very pruritic. In such a patient a very careful history will assist a great deal. The patient's daily life and routine must be examined very closely; his work must be gone over step by step. It may be a new suit or a new silk dress is the offending agent. We recently saw a young lady with a puzzling dermatitis of her face, neck and hands. The process would flare up all of a sudden, then go away for a few days or a week, only to return again. Very careful questioning gave us little help. Finally, one day when she was visiting at the office and telling us about the new attack she mentioned the fact that the gentleman friend to whom she was engaged had recently come to her town to see her. Her skin had immediately broken out following this visit. We then went into the history carefully, checked up the previous flare ups of the disease and found that each time her friend came to visit her, her trouble flared up. After much study it was finally found that her trouble was due to a toilet preparation that her friend was using on his hair. It was a resorcin solution, and a patch test made on her arm with some of this toilet preparation gave a violent reaction. He has since discontinued his toilet preparation on the hair and the skin trouble is a thing of the past. This illustrates the necessity of a very careful and painstaking history.

With a female patient the entire question of cosmetics must be gone into very carefully, a henna rinse may be the cause of a patient's skin eruption, a new toilet water may be irritating through its oil of bergamot content. Moreover, the onset of the disturbance and its relation to other factors, for example, change of work or change of location, are also of great help in making a diagnosis. The distribution of the eruption may also assist greatly. The man with a trade eruption generally has the trouble over his hands, forearms, face, neck, and perhaps genitalia. The patient that is poisoned from a new toilet seat will have an eruption over the buttocks only. We recently saw a gentleman with an eruption over his face, neck and hands. He took a trip to California and while he was out there the trouble went away entirely, but immediately on his return to Cleveland the trouble flared up once more. We then went into the history carefully and found that his wife was using orris root on her hair. A patch test with orris root powder on the man's arm gave a violent reaction. To be sure, such clear cut and striking examples are not met every day, and even then they are only solved after very close and painstaking study of the patient, of his life and of his entire surroundings.

It goes without saying that a careful physical examination is very necessary in all of these cases. Here the relation to internal medicine is of great moment. Perhaps a related asthma may be revealed; a hyperglycemia may be the cause of a patient's whole trouble. Again, food tests may be of help. In certain cases a patch test may be employed. Again, we may try elimination diets. Thus satisfactory diets have been worked out, eliminating in turn wheat, milk and eggs. In certain cases of chronic eczema, especially in younger individuals, it may be that eggs will be found as the causative agent. We repeat that in certain of these cases of chronic eczema and chronic dermatitis only the most careful study and supervision will help us to arrive at the cause of the condition.

TREATMENT

Our paper is to arouse interest in newer developments along the line of eczema research. We can hardly hope to cover the item of treatment in

such a paper. After all, the treatment in certain of these cases depends very much on finding the cause of the trouble. Many times better results will be achieved with boric ointment or with official unguentum aqua rosea than with some patent remedy that contains about 50 different articles. It is true that in old chronic cases stimulation may be necessary, using tar, liquor carbonis detergens or resorcin in suitable ointment bases. The item must not be forgotten also that certain individuals are susceptible to lanolin and in a few instances we have found that by the elimination of lanolin from the ointment base that the patient did better; this is not always the case, however. We have often noted the fact that the patient's dermatitis has been treated, before seeing us, by the quartz lamp. It has been our experience that the quartz lamp, instead of helping an eczema or dermatitis, generally irritates it. On the other hand, roentgen therapy, in the hands of experts, is of great value in most all cases of dermatitis. It must be used, however, with great care, and it cannot be used forever. The handling of an old chronic case of eczema or dermatitis, from the standpoint of finding the cause, of studying possible internal factors involved, and of properly treating it, is a major problem in medicine.

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DISCUSSION

MILTON B. COHEN, M.D., Cleveland, Ohio: I think the Medical Section should be congratulated in having heard a paper on this subject by Dr. Cole. I agree with Dr. Cole about those cases of eczema or dermatitis which are of the contact type. These do give evidence of their etiological factors when patch tests are made with the offending substances. Dr. Cole has not made clear, however, that there are many cases of eczema associated with internal causes and that these must be differentiated from the external ones if proper diagnosis and therapy is to follow. In most instances these can be differentiated clinically. The internal ones occur in childhood most frequently and in individuals who have asthma, hay fever, urticaria or other manifestations of allergy and who often give a family history of allergy. The lesions occur chiefly in the folds of the elbows and knees and around the hair line of the head and behind the ears. The skin is thickened and has a grayish purple color. There are no vesicles. The external type usually occurs on the exposed surfaces, most commonly in adults, is not associated with other allergies and always presents vesicles either clinically or microscopically. The internal ones are due to foods or inhaled substances to which there is a sensitivity, and scratch or intradermal tests will reveal the offending substances. Patch tests are of no avail. In the external ones, scratch and intradermal tests are negative but patch tests reveal the cause. It is very important therefore to apply the proper tests when studying eczema.

CHARLES J. SHEPARD, M.D., Columbus, Ohio: Eczema has long been an engima, and the dropping of the name has been suggested. Dr. Cole has covered the topic thoroughly, excepting treatment. For acute, rapidly spreading inflammatory types, whether we say dermatitis or eczema, nothing is better than wet dressings, after the acute symptoms have subsided, using a paste part time, or a paste all the time will prove beneficial. A paste is much better than an ointment as it allows evaporation. Later more stimulating applications may be needed as tar or salicylic acid mixtures.

Naturally, in any disease as varied in its etiology and clinical manifestations as eczema, there is no medicine either internally or externally that will act as a specific.

NEW BOOKS

International Medical Annual, by Carey F. Coombs, M.D., F.R.C.P. and A. Rendle Short, M.D., F.R.C.S., a year book of treatment and practitioners' index. William Wood and Company, New York, publishers.

Pharmacology of the Medicinal Agents in Common Use, by Stanley Coulter, Ph.D., dean emeritus of the Purdue University School of Science; a compact treatise of the pharmacology of the drugs now in common use by the medical profession, consisting of 254 pages, 3 and 3/8 by 6 inches, in flexible fabricoid binding. Eli Lilly and Company, Indianapolis, publishers. Price 50 cents.

The Sputum, Its Examination and Clinical Significance, by Randall Clifford, M.D., associate in medicine, Peter Bent Brigham Hospital and assistant in medicine, Harvard Medical School; The Macmillan Company, New York, publishers. Price $4.00.

Mental Deficiencies Due to Birth Injuries, by Edgar A. Doll, Ph.D., director of research, The Training School at Vineland; Winthrop M. Phelps, M.D., professor of orthopedic surgery, Yale University School of Medicine, and Ruth Taylor Melcher, M.A., research assistant, The Training School at Vineland; The Macmillan Company, New York, publishers. Price $4.50.

Four volumes in the *Everyday Practice Series*, edited by Harlow Brooks, M.D., and published by J. B. Lippincott Company, Philadelphia and London:

Orthopedics in Childhood, William L. Sneed, M.D., attending surgeon, Hospital for the Relief of the Ruptured and Crippled, New York.

Functional Disorders of the Gastrointestinal Tract, William Gerry Morgan, M.D., professor of gastroenterology, Georgetown University Medical School.

Posture, Frank D. Dickson, M.D., orthopedic surgeon, St. Luke's Hospital and the Kansas City General Hospital, Kansas City, Mo.

Functional Disturbances of the Heart, Harlow Brooks, M.D., editor of the series and attending physician, Bellevue Hospital, New York.

The Purchase of Medical Care Through Fixed Periodic Payment, by Pierce Williams, member of the staff of the National Bureau of Economic Research, Inc., 51 Madison Avenue, New York City. Price $3.00. A 300-page report of a study of various plans now in operation in the United States in which medical care "in kind" is furnished on a fixed periodic payment basis.

Bone Tuberculosis: The Relative Value of Operative and Non-Operative Treatment

Walter A. Hoyt, M.D., F.A.C.S., Akron, Ohio

Until the advent of modern methods of operative procedures of bone tuberculosis, the medical profession was fairly well agreed on the general routine of its treatment. We now find a marked difference of opinion, varying from those who are convinced that all cases should be operated, to those who believe that there is no field at all, for major operative measures. Because of these radical differences of opinion, it seems permissible to discuss the subject from a neutral point of view, with an attempt to evaluate the relative importance of both the operative and conservative treatment of bone tuberculosis.

Until thirty years ago, in the minds of the whole medical profession, joint tuberculosis was a non-operative condition. Such cases came under the care of men who were willing to work along with them for many years, attempting to maintain rest and immobilization. Few institutions were available for the work and the results were far from satisfactory. With the development of institutions and the widespread study and interest in the tuberculosis problem, large groups of bone tuberculosis cases were brought together under the supervision of a small group of men.

The grouping of these cases in institutions, opened up the opportunity for better hygiene, fresh air and outdoor life. Soon heliotherapy, both from sun and artificial lamps, was developed. Reports of end-results of large groups of cases followed, showing varying results from movable joints with no shortening, to bony and fibrous ankylosis with or without deformity.

During this period, these men had the opportunity of seeing their end-results, five, ten, fifteen and twenty years later and were impressed with the rather large number of patients who, although treated over a long period and under ideal conditions, recurred under the strain and duties of ordinary living. They were returning for further treatment. Not satisfied with their results, some of these men now turned to surgery. At first, attempts were made to excise the diseased joint and tissue, hoping for a good bony ankylosis. With the development of bone surgery, new methods of fusion and arthrodesis have been introduced, which have been a great aid in obtaining better end-results.

CONSERVATIVE TREATMENT

The principles of the conservative treatment may be summed up in rest, immobilization, and methods directed toward the arresting of the local and constitutional disease. The use of good hygiene, special diets and fresh air are so generally accepted that little need be said concerning them. The limits of this paper do not permit the discussion of all angles of this treatment but many of them are taken for granted as being in use in any institution well equipped to care for bone tuberculosis.

HELIOTHERAPY

Heliotherapy is the scientific application of the sun's rays in the treatment of disease. In tuberculous processes it probably has its best application. First advocated by Rollier in Switzerland in 1903 and later introduced into this country in 1913 by Hyde at Perrysburg, New York, and Springfield Lake Sanitorium in Akron in 1921, it has definitely established itself as a great curative agent in bone tuberculosis. No attempt will be made to discuss the physics, chemistry, technique of administration, or theories of heliotherapy as they have been so well described by other writers.

When given scientifically and in the properly selected case, certain very definite results can be expected of heliotherapy. Constant irradiation of the whole body causes pigmentation of the skin, stimulates physiologic functions of the skin, improves respiration, increases metabolism and appetite and undoubtedly stimulates the endocrine glands. Relaxed, atrophied muscles, increase in size and regain their tone even without activity. Weight increases and normal growth takes place.

The influence of heliotherapy on diseased bone is very definite. First, increased activity is observed, followed by absorption of necrosed areas. Later the bone becomes more opaque, density and dimensions are increased, and fusion begins to follow. Abscesses and inflammatory exudates may appear to increase at first but as treatment goes on, these tend to decrease in size or calcify. Cases with secondary infection and draining sinuses usually increase in amount of discharge at the onset followed by decrease and eventual closing. In observing the cases treated by this method, one gets the impression of an acute onset of the pathological process, followed later by a complete evolution and repair.

We do not wish to give the impression that heliotherapy is a cure-all for bone tuberculosis. Many cases will not tolerate sun treatment at all and have a marked increase in their symptoms and pathological processes. Such cases must be recognized early and treatment regulated accordingly. Cases of marked general tuberculosis, far

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advanced pulmonary disease with caseation, heart lesions and high blood pressure, are probably contraindicated to the treatment. Because of the rapid absorption which follows the institution of heliotherapy, it may be necessary for early and frequent aspiration of abscesses whenever they can be reached. This will often prevent secondary infection and the necessity of incision and drainage. Unless secondary infection is definitely established, incision is absolutely contraindicated.

From observation of cases treated with and without heliotherapy during twelve years' experience with its use, we are definitely convinced that it is a big step forward in the treatment of bone tuberculosis. We are not enthusiasts and realize its dangers and limitations. To be effective it must be used scientifically and according to the methods originally proposed by Rollier. It is not irradiation of a local area but must include a sun bath of the whole body. In spite of the wide publicity that has been given it by Rollier in Switzerland, and Hyde and others in this country, I am convinced that there are very few places where it is correctly carried out. This may account for the fact that the end-results reported by Rollier and English writers, seem to be better than in America. Kidner however, feels that it is a difference in the virulence of the infection on the two sides of the Atlantic. Those who condemn and criticize it are usually uninformed and have used it unscientifically and unintelligently.

Immobilization and physiological rest is of course a well recognized part of the treatment of any case of bone tuberculosis. The various methods of accomplishing this are many and familiar to all. This may be carried out by plaster casts, shells, ambulatory splints and braces or by recumbency on frames with extension.

In the acute state there is no place for ambulatory methods. One is dealing not only with a diseased hip or spine but with a potential general tuberculosis. For this reason, all cases should be treated in recumbency in such a manner that the whole body as well as the local disease has physiological rest. Attention at all times must be given to the prevention of deformity and the retaining of neutral position or the position of election for good function. Spines are best treated by plaster shells or corrective hyperextension Bradford frames, hips and knees by light leather extension which can be easily removed, ankles and wrists by molded removable splints and elbows and shoulders by light removable abduction splints or extensions. A type of apparatus should be used that will not interfere with the use of heliotherapy so that the whole surface of the body may be exposed.

In the beginning, rigid immobilization is maintained but as the disease becomes arrested, more freedom is allowed but recumbency is still maintained until it seems advisable to give the patient the test of activity and weight bearing. At this point we advise use of ambulatory braces.

Experience has shown that in most cases, only after long observation should they be classified as arrested. Results of the conservative treatment will show fusion in a certain percentage of cases of the major joints with marked improvement of both the local and general disease. The objection to this method is that unstable joints are apt to be the end-result after the second decade of life and then will not stand the test of use without recurrence. The long period of hospitalization is also a great economic objection.

SURGICAL TREATMENT

The discussion of the surgical treatment of bone tuberculosis will be confined to fusion and arthrodesis of joints. Reports of end-results of a large series of cases and the work of Hibbs, Baer, Albee and many others have conclusively demonstrated the advisability of doing away with radical excision of tubercular joints. This type of surgery has led to flail and unstable joints with persistent draining sinuses. There is probably a place in certain selected cases for this type of operation in the ankle and elbow. When, however, the ideal extra-articular arthrodesis has been devised for these joints, excision will not be indicated.

In reviewing the literature for the past thirty years, one finds that once operation has been decided upon in a given case, there is only one goal to be sought. The two principles used to obtain this goal are agreed upon by most surgeons today. These principles may be summed up as follows: First, to establish a bony fusion of a joint in the position of election, and second, to accomplish this procedure by operative methods which are carried out extra-articularly and in such a manner that the pathological process is not disturbed. Once surgery has been resorted to, there is only one result to be obtained and that is a solid fusion of the joint or joints attacked. There is no place for a movable joint and if there is still mobility after operation, the procedure has been 100 per cent failure.

The method of choice is that method which considers the two principles as above stated, has the lowest mortality and the best results after five to ten years. From end-results of our own cases and reports of other men, the methods of choice are those advocated by Hibbs. The Hibbs method has been used in practically all of our cases of the spine, hip and knee. In cases of the lumbar spine, osteoperiosteal grafts have been used in addition to the usual procedure. Probably the ideal operation has not been devised for some of the other joints but the technique advised by Hallock seems to meet all the requirements for fusion of the elbow and the extra-articular arthrodesis of the shoulder by osteoperiosteal graft is the operation of

choice. The wrist and ankle, if operated, are probably best treated by arthrodesis with partial excision.

The advantages of surgical treatment are obvious. In a relatively short time a good firm bony fusion can be obtained which gives complete immobilization and physiological rest to the pathological tissue. the results are permanent and the joints safer to withstand the trauma of normal activity and local recurrence of the disease is greatly diminished. From an economic standpoint the disability is much shortened. There are however, certain disadvantages. The chief danger is that of treating a local condition as an entity and ignoring the general disease. While the operative procedure has been done primarily to shorten treatment, there is danger in assuming that the patient and surgeon have nothing to strive for but an operative recovery. It is difficult to obtain a good fusion in children and there are objections to disturbing epiphysises and growing bone. When operative failure is not recognized and the case reoperated, results are worthless.

STATISTICS

The following statistics are taken from a study of the bone cases admitted to Springfield Lake Sanatorium and Molly Stark Sanatorium for the past ten years. They represent cases in all stages of the disease and no selection is made. In all, 158 cases are included. Of this number, 143 were whites and only 15 blacks, in spite of the fact that there is a rather large negro population.

CHART I.

DISTRIBUTION OF LESIONS

Ages in Years	0-5	6-10	11-20	21-30	31-40	41 & over	Total
Number of Bone Cases Studied.	30	20	31	41	15	21	158
Spine	13	14	16	21	14	3	81
Hip	6	12	8	6	3	5	40
Knee	7	1	5	4	1	2	20
Ankle	2	1	6	6	2	1	18
Ribs and Sternum	0	1	1	4	2	1	9
Wrist and Dactylitis	1	0	3	2	1	2	9
Shoulder	0	0	1	1	0	1	3
Elbow	2	0	1	1	0	0	4
Jaw	0	0	1	2	0	0	3
Sacro iliac Joint	0	1	3	3	2	2	11
Kidney	2	2	6	9	5	2	26
Bladder	0	0	1	0	2	0	3
Epididymis and Testes	0	0	2	5	2	0	9
Peritonitis	2	0	1	0	0	0	3
Pleurisy	1	0	9	2	1	1	14
Empyema	1	1	3	0	0	0	5
Pulmonary	4	3	10	19	13	11	60
Enteritis	0	1	0	3	2	1	7
Laryngitis	0	0	1	2	1	1	5
Meningitis	0	0	0	3	0	0	3
Hilum Nodes	20	8	5	0	0	2	35
Cervical Glands	4	2	1	5	2	1	15
Inguinal Glands	1	1	1	2	0	0	5
Number of Lesions Found	66	48	85	100	53	36	388

CHART II.

AVERAGE ONSET IN YEARS BEFORE ADMISSION

Age in Years	0-5	6-10	11-20	21-30	31 40	41
Average No. of Yrs. of Symptoms before Admission	1½	3½	5	2½	4¼	9¼

Shortest Duration—2 months.
Longest Duration—40 years.
Average—4.4 years.

CHART III.

MAIN LESIONS OF PATIENT ON ADMISSION

Spine	69
Hip	28
Knee	11
Ankle	11
Sternum	2
Wrist	2
Sacro iliac Joint	4
Shoulder	1
Cervical Adenitis	1
Peritonitis	1
Dactylitis	1
Pulmonary	27
Total	158

CHART IV.

RESULT OF TREATMENT

Died	33
Unimproved	15
Improved	28
Quiescent	20
Arrested	62
Total	158

There was a history of injury in 35 cases, or 22 per cent, previous to the onset of the disease.

The number of years of onset of the disease averaged 4.4 years previous to admission, with the shortest duration two months and the longest 40 years.

While all cases had bone lesions, there were 28 cases with other conditions named on admission, as the main lesion.

The accompanying chart illustrates the location of the disease according to part involved, multiplicity of lesions and ages. With the 158 cases, there were 388 separate foci of infection. Only 31 cases showed a single bone lesion without other lesions. The smallest number of lesions was one per patient and the greatest 11. The average of lesions per patient was 2.6. The number of patients with one bone involved was 136 while 22 had more than one bone lesion.

The results of treatment are enumerated in a separate chart. The number of deaths illustrates the severity of the cases. No case was charted as cured and no attempt has been made to classify end-results as to location or type of treatment. At a later date when sufficient time has elapsed, we expect to report end-results after five-year periods.

Tuberculosis must be considered as a general disease and any bone involvement is only one

manifestation of it. I wish particularly to draw your attention to these facts in our statistics, namely; that in 158 cases of bone disease there were demonstrated 388 lesions. Only 31 cases showed a single bone lesion unassociated with other evidence of tuberculosis. We feel certain that many of these 31 cases, if observed long enough, would or will show other signs of disease. The original location of the disease is probably never in bone but as Gohn and others have so well shown, it is primary in the lung or peribronchial nodes. With such overwhelming evidence as this, corroborated by the reports of other large series of cases, one is forced to consider the treatment of bone tuberculosis as a joint medical and surgical problem. No longer can we think of tuberculosis of the hip, spine or knee as an entity, but as a general medical disease with local manifestations in these joints. It is not a problem for the orthopedist alone, nor should it be left entirely in the hands of the internist. Only by frequent consultations and examination by both, can the safe and ideal treatment be arrived at. Unfortunately such cooperation does not exist in all communities and in many places we find the orthopedic surgeon or the medical man working separately. Such a condition of affairs tends to develop narrow enthusiasts and no one is penalized except the patient.

COMBINED SURGICAL AND CONSERVATIVE TREATMENT

For the last fifteen years as consultant to Springfield Lake Sanatorium in Akron, the Children's Hospital in Akron, and for a shorter period at the Molly Stark Sanatorium in Canton, I have had the opportunity to study, treat and observe a large consecutive series of bone tuberculosis. All of these institutions are well equipped to study scientifically these cases and furnish facilities for the ideal conservative or operative treatment. As the result of this experience and review of our cases, I am thoroughly convinced that the conservative handling of bone tuberculosis is not sufficient in itself. I am also convinced that the care of bone tuberculosis by operative means alone, is equally inadequate. Only by the wise combination of both types of treatment can we hope to approach the ideal solution of this important problem. However, if only one type of treatment were available, I am sure that I would choose the conservative and not the operative.

We feel that the operative treatment is one more adjunct in the handling of the whole problem. Just as heliotherapy combined with good sound orthopedic principles was a big step forward, so also is surgery in the properly selected cases and combined with all the other sound conservative methods. In the years when we did very little surgery, we kept cases for long periods of time with their general systemic disease cured but with a non-fused joint. Such a case would be operated today after a reasonable period of convalescent treatment. On the other hand, we have seen many cases admitted to the sanatorium after they have been operated upon without preliminary or post-operative conservative care. Their operative result was good but they had other foci of infection, either in another bone, testes, chest or intestines. We likewise have reviewed cases which had been operated but which did not have a good fusion. These had recurred locally and no attempt had been made to reoperate them. If fusion is indicated and is a failure, it should be reoperated as it is not possible to obtain fusion on all cases with one attempt.

We have seen cases in which we felt we had obtained a suitable ankylosis by conservative means as shown in X-ray and clinical examination. When these cases were put to the test of walking and use, they have recurred. After operation they have obtained stable joints and not recurred under use.

Cases have been admitted for pulmonary disease and after careful study have been found to have a diseased hip or spine. Also cases have been treated for lesions of the hip and during treatment have been found to have a spine lesion previously unrecognized. This leads us to the conclusion that only after a rather long period of observation, can the full extent and number of lesions be determined.

TREATMENT OF CHILDREN

The treatment of children under ten, in this whole matter, has to be considered separately from that of adults. Results of these children, particularly with hips and spines, have been good without operation. In spines we feel that we have obtained good fusion and ankylosis with minimum deformity and ones which have stood the test of strain for many years without recurrence. In the cases of hips, we have had very satisfactory results from the standpoint of fusion and weight bearing. Some have required osteotomies of the femur to relieve the fixed deformity present on admission. When a fixed deformity has occurred, we made little effort to correct it by manipulating or extension. Experience has shown me in numerous cases that it will be followed with more destruction of bone and a non-fused hip.

From observations, I am fairly convinced that the best end-results in hips in children are the ones which are entered after having been untreated for a time and there has taken place a fixed deformity in adduction, flexion and internal rotation. These cases have fused more quickly and later after osteotomy, have shown less shortening and destruction. Many of our cases of course, have had poor fusion and variable mobility. Some of them with mobility have done well on weight bearing but as a rule are unsatisfactory and later have come or will come to

operation. In spite of our earlier optimism and the work of Rollier and others, we feel that a movable joint, as a rule, is undesirable and when we have one in which there appears to be normal joint surfaces and full motion, we are inclined to doubt our original diagnosis.

In knee cases of children, we are satisfied with the end-results by conservative treatment. Here we have had some very good fusions and also some movable joints, which up to the present time are standing the test of strain very well. In all other bone tuberculosis in children, we are convinced that conservative treatment only, is indicated. This group includes knees, wrists, elbows, ankles and dactylitis. Until we have better proof from the results of our own operative cases, and the reports of others, we shall continue to treat children before the second decade of life, with bone tuberculosis, by heliotherapy and conservative methods.

ADULT BONE TUBERCULOSIS

When adult bone tuberculosis is considered, the picture is different. These cases comprise patients who have developed lesions in late life or who have not obtained a good fusion in childhood, for one reason or another. From observation and study of end-results, in spite of my previous enthusiasm, I am forced to dispose of the treatment of this group of cases by one word—operation. This is qualified by the statement that the general condition must be treated before and after operation by conservative methods. Cases must be selected carefully for operation. A patient with a draining sinus I do not feel is a favorable one for operation. Such a case should have further heliotherapy and conservative care. Persisting sinus after operation can be accounted for in two ways. First, the case may have been operated incorrectly in the presence of a draining sinus or secondly it may be the result of secondary infection following operation. The latter, I believe is the most common cause. For this reason fusion operations should be done only by trained men, who will carry out with meticulous care, Lane technique and use good judgment as to the proper time to operate the patient. Following such a course will practically eliminate post-operative draining sinuses. In our series of 22 major fusions, we have not had one persisting sinus from any cause.

CONCLUSION

In conclusion, in view of the fact that bone tuberculosis is one manifestation of a general infection, cases should be admitted to an institution for the conservative treatment of tuberculosis. Here the case must be cared for as a medical problem and treated along conservative lines. Trained and competent consultants in each department should be available with facilities for careful scientific investigation, in all fields. Complete records and repeated *X*-ray studies are necessary. Sound orthopedic methods and principles should be in use in order to maintain immobilization and prevent deformity, but must be of such a type that they will not interfere with honest, well regulated heliotherapy.

Because most of the cases will have a long stay, every effort is made to make the surroundings as ideal as possible; and schools are essential. Each patient must be considered as an individual problem and no general rule can be made to apply to him. When after repeated conferences of both medical and surgical men, the case is considered quiescent and ready for operation, then that procedure can be carried out. It may be after six months, one, two, three or four years' stay. After operation, the case is again admitted to the sanatorium and the same conservative treatment is carried out until again the combined medical and surgical consultants are convinced that the patient is sufficiently recovered to stand the strain of ordinary life. The position is taken that even though the patient has had a fusion operation for a spine or a knee lesion and has a good clean operative result, he still has bone disease and must be treated for it. Likewise no patient is discharged without operation, until all are agreed that the general disease is arrested and that a suitable fusion has been obtained. After discharge from the sanatorium. they are all automatically referred to follow-up clinics where they are examined from time to time by the same men who originally took care of them. Should any difficulty or recurrence arise, it is discovered early and the patient is readmitted to the sanatorium.

With such cooperation between the medical and surgical men, and with the combination of both the non-operative and operative methods, as outlined above, we feel that there will ultimately come the best end-results in patients suffering with bone tuberculosis. At this time I wish to thank Dr. C. L. Hyde, Medical Superintendent of Springfield Lake Sanatorium and Dr. E. B. Pierce, Medical Superintendent of Molly Stark Sanatorium, for their cooperation and help in carrying on this work and in the preparation of this paper.

SUMMARY

(1) Tuberculosis of bones must be considered as one manifestation of a general disease as evidenced by the fact that 76 per cent of bone cases have other foci of infection in evidence.

(2) The treatment of bone tuberculosis is a joint medical and surgical problem.

(3) Heliotherapy and conservative measures are the proper treatment for all cases whether operated or not.

(4) Until better proof of end-results is given, children up to the second decade should as a rule, be treated by conservative methods only.

(5) Adult cases should all have preliminary treatment by conservative methods. When the general disease is quiescent, fusion operations should be done on the major joints. A long period of operative convalescence must be carried out with heliotherapy methods.

(6) The desired end-result in all cases, is ankylosis.

(7) The goal of operative methods is an ankylosis. When this does not result, reoperation should be done. Extra-articular operations are the ones of choice.

428 OHIO BUILDING.

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Studies in Rickets V. Relation of Diet During Pregnancy to the Development of the Children at Seven Years of Age

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FOR the past seven years we have been studying the effect of the prenatal diet of a group of pregnant women upon the development of their offspring. The diets of 25 mothers were supervised during the latter half of pregnancy by visiting dietitians and daily records kept of the food actually ingested.

The incidence of rickets at eight months of age among the offspring of these mothers and the condition of their teeth at four years have been reported in previous communications[1,2].

Eighteen of the offspring, who at the time of this report were seven years old, were available for the present study. All of them were colored children. Chart I shows the main facts regarding the condition of the children at the time of the study. The cases are arranged in the order of the average daily caloric intake of the mothers during pregnancy. As stated in our previous studies, there was considerable variation in the amounts that these mothers could be induced to eat, but the vitamin and mineral intake was adequate in all cases, according to the standards existing at that time, the adequacy of which have been questioned by Toverud and Toverud.[3] The double lines of the chart divide the cases into groups of less than 1500 calories, from 1500 to 1700 calories, and over 1700 calories daily.

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*From the B. K. Rachford Department of Pediatrics, University of Cincinnati, and the Babies Milk Fund Association of Cincinnati.

CHART I

Case	Sex	Mother's Prenatal Diet, Av. daily Calories	*Degree of Rickets at 8 Months* Clinical	Roentgen-Ray	*Present Condition* Age	Height Inches	Weight Pounds	Nutrition	Bones	Caries Deciduous Teeth	Permanent Teeth No.	Caries
18	♂	1,380	+++	+++	6yr. 9mo.	45½	51	good	flat feet large head & bosses, bow legs	3	6	—0
23	♀	1,400	+	+	7yr. 2mo.	42½	40	good	OK	11	6	—0
25	♂♀	1,449	+	+++	6yr. 7mo.	46½	50	good	OK	0	2	—0
5	♀	1,463	+	+	6yr. 11mo.	49½	57¼	good	OK	8	10	—4
7	♀	1,499	+++	+++	6yr. 6mo.	44	36½	unsatisfactory	OK	6	3	—0
21	♀	1,500	+	+++	7yr. 2mo.	47¾	56	good	knock knee	3	6	—2
11	♂	1,521	O	+	7yr. 2mo.	46½	47¼	good	OK	0	8	—2*
10	♂♀	1,524	+++	+++	7yr. 2mo.	45½	44	poor	OK	8	6	—2
9	♂♀	1,529	+	+	6yr. 7mo.	49¼	58½	good	sl. bow legs	4	1	—0
6	♀	1,573	O	+	7yr. 1mo.	48½	57	good		1	10	—0
12	♀	1,612	+	+++	7yr. 1mo.	45	43	unsatisfactory	OK	9	6	—2*
13	♂	1,666	O	+	7yr.	45½	48	good	pigeon breast	4	10	—0*
4	♀	1,706	O	+	7yr. 2mo.	48½	43	unsatisfactory	OK	5	6	—3
14A	♀	1,969	+	+	7yr. 1mo.	46½	46	good	OK	0	10	—0
14B	♀	1,969	+	+	7yr. 1mo.	46½	46½	good	OK	0	*	—0
15	♀	1,995	not seen at 8 months		6yr. 6mo.	46	50	good	sl. bossing of head, pigeon breast	2	7	—0
17	♀	2,023	+	O	7yr. 1mo.	46	44	unsatisfactory	OK	*4	10	—2*
3	♂	2,322	+	O	7yr. 1mo.	45½	40¾	unsatisfactory	OK	7	7	—0

* Hypoplasia

CHART II

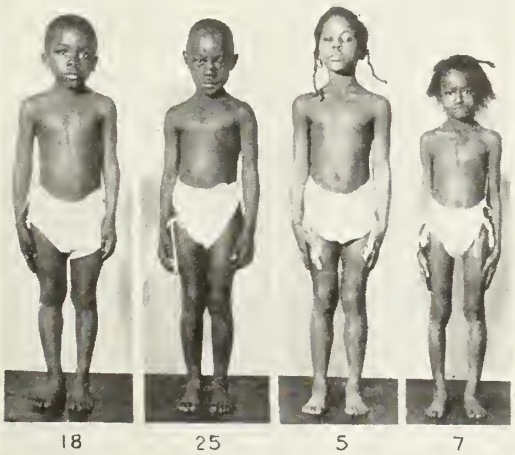
RELATION BETWEEN DEGREE OF RICKETS AT 8 MONTHS OF AGE AND PRESENT PHYSICAL CONDITION

Rickets at 8 months		Unsatisfactory Nutrition		Bony Abnormalities		Children with Caries of Deciduous Teeth		Carious Deciduous Teeth per Mouth	Children with Caries of Permanent Teeth		Carious Permanent Teeth per Mouth	Hypoplasia of Permanent Teeth		Av. Ht. Boys	Av. Ht. Girls	Av. Wt. Boys	Av. Wt. Girls
	No.	No.	%	No.	%	No.	%	No.	No.	%	No. %	No.	%	In.	In.	Lbs.	Lbs.
Mild —	11	3	27	2	18	8	73	4.0	4	36	1.0	3	27	45.8	47.2	45.3	49.0
Marked —	6	3	50	2	33	5	82	4.6	3	50	1.0	1	17	45.8	45.6	48.3	45.2

The present state of nutrition, judged clinically and checked by the height-weight relation, shows a larger percentage of unsatisfactory nutrition among children whose mothers had a higher caloric intake during pregnancy.

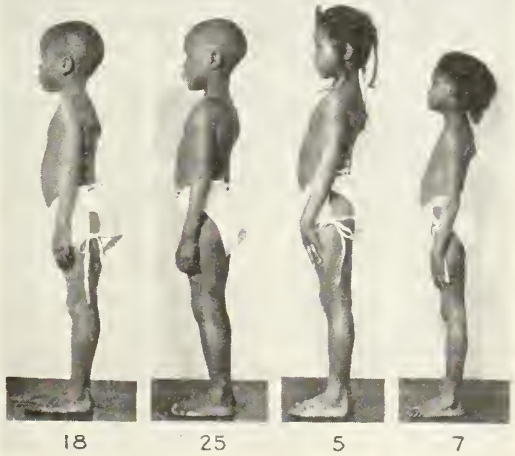
Bony abnormalities were few and none pronounced. When they occurred they were found mainly in the second group, i.e., in those whose mother's prenatal diet was between 1500 and 1700 calories.

FIG. I.



18 25 5 7

FIG. Ia.



18 25 5 7

Caries of the deciduous teeth was most prevalent among children whose mothers consumed diets of less than 1700 calories. This is evident both in the percentage of children with caries and in the average number of carious teeth per child. The molars and canines were the temporary teeth studied. Cavities and filled and missing teeth were employed as evidence of caries.

The permanent teeth (six year molars and incisors) showed a slightly greater incidence of caries among children of those mothers whose diet was in the 1500-1700 calorie group than in the groups with higher and lower caloric intake. These teeth being formed mainly after the birth of the child, might be expected to be influenced more by postnatal than by prenatal conditions.

When the relation of the degree of rickets at eight months to the present condition (Chart II) is studied, it is noted that the children of the group which had mild rickets at eight months of age had a consistently lower incidence of unsatisfactory nutrition, of bony abnormalities, and of caries of both temporary and permanent teeth than the group with marked rickets. However, hypoplasia or defect of the enamel of the biting edge of the permanent teeth was found more often in the mild rickets group.

We have used the term "mild rickets" since the cases were so designated in our earlier papers. Subsequent studies[4,5] by serial roentgenograms and according to more modern criteria make it probable that some of the changes in the roentgenograms accepted as rachitic should more properly be classified as physiologic.

When the relation between the present state of nutrition and the incidence of dental caries is studied, it is noted that of the twelve children with good nutrition eight, or 75 per cent, had caries of the deciduous teeth, and three, or 25 per cent, had caries of the permanent teeth, while of the six children with unsatisfactory nutrition, all (100 per cent) had caries of the deciduous teeth, and four, or 67 per cent, had caries of the permanent teeth. Thus there was a

FIG. 2.



FIG. 2a.



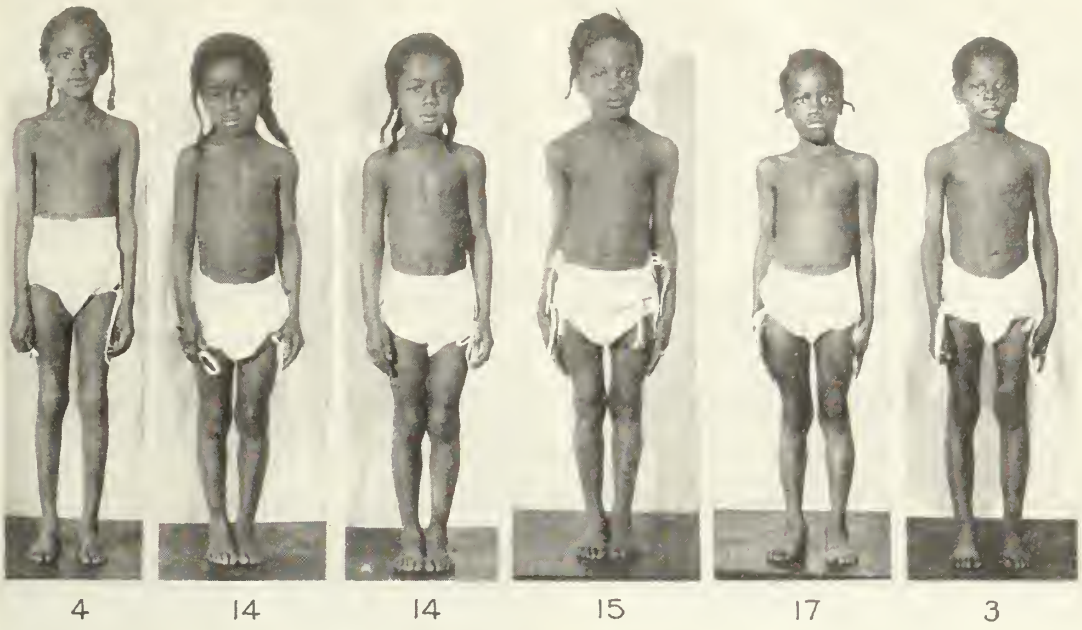
smaller incidence of dental caries among the better nourished children.

We have been unable to find in the literature any similar study of human cases reporting the relation between accurately observed prenatal diet and the condition of the offspring, although the relation between rickets in infancy and the later condition of the children has been reported by Mackay and Rose[6] and Hess and Abramson[7].

Mackay and Rose recorded certain items of the physical condition of children of school age who had had rickets in infancy. Of their group 25 cases were of the same age as the children of the present study. These were compared with a control of 17 children, and it was found that while there was about the same incidence of dental caries in the two groups, the children who had had rickets were somewhat lighter in weight and shorter than those of the control group.

Hess and Abramson, studying a group of children of the same age as those in the present study, in whom the presence or absence of rickets had been recorded in infancy, found a somewhat greater percentage of caries of the deciduous teeth in the rachitic group and a slightly smaller percentage of caries of the permanent teeth in the same group. They state that while rickets may play a role in the etiology of caries of the

FIG. 3.



4 14 14 15 17 3

FIG. 3a.



4 14 14 15 17 3

deciduous teeth it cannot be considered the dominant factor.

From our studies no definite conclusions can be drawn, but certain interesting relations are shown of the prenatal diet of the mothers as well as of the degree of rickets in infancy, to the state of nutrition, bony development and condition of the temporary and permanent teeth of children at seven years of age.

DISCUSSION

J. V. GREENBAUM, M.D., Cincinnati: This paper illustrates the difficulties of proving or disproving repeated assertions which are not based upon experimental evidence in human beings. It has become a part of medical literature that proper diet during the prenatal period will go far to prevent such conditions as rickets disorders of nutrition and caries of the teeth in the offspring. Our work during the past eight years has not

borne out these assertions as you can see. There is no question but that proper diet during pregnancy will favorably influence the offspring but that is as far as anybody can state at present.

It is also frequently asserted that rickets during infancy is the cause of poor dentition, bony abnormalities and the like. From a study of our cases at present and the enlargement of the wrists at eight months, you will note that this is not the case since some of the children with the best teeth, perfect nutrition and bony structure had the worst rickets in infancy. Therefore properly treated rickets during infancy apparently leaves no residual effects. We intend to continue this work as long as is possible to keep in touch with these children.

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A Practical Program for a State Mental Hygiene Association

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IT is manifestly impossible for physicians solely and alone to work in the broad field of mental hygiene. Here, as in other fields of public health, other professions whose concern is chiefly with Man in some aspect of his humanity have much to contribute. Leadership, however, should remain in the hands of the medical profession. Failure on the part of the medical profession to adequately prepare itself and refusal to interest itself in this newer field of public health work is bound to turn the mental hygiene movement over to lay people with subsequent dangers of charlatanry.

The Ohio Mental Hygiene Association is a relatively new organization. It was organized on February 19, 1930. Its purpose may be stated as follows: "To conduct general education in mental hygiene. To promote adequate service by state and local agencies, public and private, especially in the care, treatment and supervision of the mentally deficient."

MENTAL HYGIENE DEFINED

First of all, let us try to define mental hygiene. Numerous definitions of this broad term have been offered. Frankwood E. Williams[1] puts it as follows: "In attempting to define mental hygiene one must differentiate between (1) mental hygiene as an organized social movement and (2) mental hygiene as an art in the application of knowledge derived from certain basic sciences to the maintenance of individual health". Committee B, Section on Physically and Mentally Handicapped of the White House Conference on Child Health and Protection[2] states: "Mental health implies an adjustment of human beings to themselves and to the world at large with a maximum of personal and social effectiveness and satisfactions. The highest degree of positive mental health permits the person to realize the greatest success which his capabilities will permit, together with the maximum of satisfaction to himself and society and a minimum of friction and tension."

These definitions stress the fact that mental hygiene is not only a therapeutic but even more an educational discipline. Mental hygiene is more than curative and preventive; it is a constructive socializing force.

A PRACTICAL PROGRAM

Education, therefore, is one of the purposes of the Ohio Mental Hygiene Association. But some of you at once will say, "But hasn't mental hygiene been oversold? Isn't much of the mental hygiene propaganda harmful or even vicious?"

Psychology has been popularized, even vulgarized. People's appetites have been whetted and they are asking for more. They insist on getting it. Under present market conditions they will get it from one source or another. That harm has been done through this overpopularization is unquestionably true. But by far the greater harm has been done through the failure of those whose legitimate function it is to safeguard health to adequately prepare themselves to offset the vicious propaganda and unsound and harmful therapeutic approaches in the hands of the partially trained and totally untrained in the art and science of medicine. If medical men merely scoff and sneer and make no effort to recognize that the whole man needs treatment and care they have only themselves to blame if the lay analyst and consulting psychologists and psychoclinicians

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choose to advertise their wares. Read what the *New York Herald* had to say on this score in a recent editorial:[3]

Misinterpretation [of mental hygiene] is fostered for profit, in every city of this country, by a great many tinkers with human mentality who operate, unqualified and unlicensed, in the shadow of psychiatry. These tinkers cannot call themselves psychiatrists because they have no medical degree; but there is nothing to prevent any solemnly glib practitioner of what they safely call "psychology" from tampering with the sanity of the neurotic or dyspeptic or simply tired and lonely person who falls into his clutches—at fifty a consultation. New York is full of these ultra-modern witch doctors, because it is full of tense, unsunned, unexercised people with minds so feverishly active that they cannot relax and bodies so ill-kept that their nerves are always a-jingle. It is to these people that the quacks, with the Viennese hotel stickers on their handbags for diplomas, reveal their "maladjustments" and whom they demoralize and ruin with the fears and horrors that they conjure up.

An important part of the educational program of the Ohio Mental Hygiene Association will be to see that only sound information is disseminated. This will require that all the articles written will be written by experts. It will also necessitate that the men who know what should be taught will be available as speakers and teachers. Only in this way can sound information be made available to the public.

The mental hygiene movement has already exploded many ancient superstitions and prejudices concerning mental disease. But much still needs to be done. People must come to look upon mental disease as they do upon physical disease; as an illness in need of treatment. They too must come to search out the specialist in mental disease for treatment with no more feeling of disgrace than going to the surgeon or internist for some physical ailment.

But then it behooves us to see to it that there are adequate facilities both public and private for the proper care and treatment of those already ill. Ohio is lax in meeting these needs. In May, 1930, former Governor Cooper appointed a Welfare Advisory Commission to study the situation. This Commission asked itself three questions:

(1) Does Ohio possess adequate facilities for those patients who are now in State Hospitals? If not, what additional facilities should be provided to eliminate overcrowding?

(2) Is Ohio caring for all the insane that need care? If not, how many more should now be under care?

(3) What will be the additional requirements for the next ten years, due to increase in the state's population?

As you already know, the Commission found serious overcrowding in existing institutions, an excess of 1884 patients over the proper maximum capacity. It also found that Ohio was caring for fewer patients in proportion to population than in similar institutions in the country as a whole. On the basis of 250 per 100,000 of the general population, 1558 more patients should have been under care. And in answer to the third question, the Commission estimated that an additional 2500 beds would be necessary to meet the increased population in the next ten years. That means provision for almost 6000 patients should be made within the next few years. Facilities for adequate care and treatment of the known feebleminded and epileptic are indeed meagre. And for the defective delinquent there is no provision at all.

The failure of the $7,500,000 bond issue for welfare purposes is in itself sufficient evidence that these needs are not widely known. Nor is the seriousness of the situation fully appreciated. An educational campaign is therefore urgently indicated. Such an educational campaign must reach each and every legislator elected to the General Assembly. Each legislator must be furnished data and statistics relating to these urgent needs. But he needs also to know what the mental hygiene movement is about. He must come to appreciate that an adequate program not only includes beds and bed space but that more adequate provision for the psychiatric care of the patients confined must be provided. Such a program, too, demands that he learn of the need for carrying on research which after all is the first step toward prevention. All sound information for public consumption will of necessity have its roots in the research work conducted in this field. The legislator also must learn that prevention and adequate early treatment will ultimately lessen the cost to the state in the care of the mentally ill and defective. Such a program demands an enlargement of the social service departments and the establishment of mental hygiene clinics not only for the proper after-care of patients discharged from the hospital, but also for the prevention of illness and the early treatment of patients already showing signs of maladjustment.

In carrying into effect such a program, provision must be made for the proper education of psychiatrists in extra-mural work. It is of little value to establish state hospital out-patient clinics unless the physicians assigned to them have learned to utilize in clinic treatment the community resources, such as various types of social agencies, educational groups, recreational organizations, etc. Every physician who has ever worked in a state hospital and then gone into private practice or other form of extra-mural work is keenly aware that he is not familiar with the problems met in the various types of maladjustment not requiring institutional care, and that much of his institutional experience is of little value to him in dealing adequately with his patents. Training centers in extra-mural mental hygiene work should be established of necessity in such places as offer opportunities in various

kinds of mental hygiene activity. To such centers state hospital physicians could be assigned for a period of two or three months of study and training. New York State through the Mental Hygiene Committee of the New York State Charities Aid Association has such a program in effect.

To carry out successfully any such program as herein outlined will demand an enlightened public and an educated personnel. Only through the creation of a strong public opinion will legislative bodies come to act favorably. And personnel in sufficient numbers and properly trained will not be forthcoming unless the demand constantly exceeds the supply.

There is needed, too, a reorganization of the State Department of Public Welfare. This probably can be done without legislative action. Four divisions, each with an administrative head chosen for merit and protected in his position by civil service regulations and who would hold his position through successive changes of administration, should be created. These divisions would be: (1) Administrative division handling the business and fiscal operations of the department. (2) Division of Social Welfare, a continuation of the work being done by the Division of Charities. (3) Division of Mental Hygiene. This would be a new division under a chief or head of the division appointed under and protected by civil service with rigid specifications embodying professional training and experience. The conduct and general supervision of the state hospitals, institutions for the feeble-minded, hospital for epileptics and bureau of juvenile research would be under this division. (4) Division of Correction. A new division should be established to have charge of the Ohio Penitentiary, London Prison Farm, Ohio State Reformatory, Ohio Reformatory for Women, Boys' and Girls' Industrial Schools, any new correctional or penal institutions, the present division of probation and parole, bureau of examination and classification, the board of parole and bureau of criminal identification. The chief of this division should be trained and experienced in the field of criminology and penology and familiar with the latest and approved practices of modern dealing with the criminal and delinquent.

CONCLUSION

In conclusion a practical program aims at making provision for:

1. Sound education in the entire field of mental hygiene.
2. Adequate facilities for the housing, study and treatment of persons committed to state mental hygiene institutions.
3. Research facilities including the establishment of special psychopathic units preferably in conjunction with medical schools.
4. Training centers in both intra- and extra-mural clinical work.
5. Establishment of extra-mural clinics to provide after-care facilities as well as to engage in a program of child guidance and adult mental hygiene. Such clinics to be staffed with trained psychiatrists, psychologists, and psychiatric social workers.
6. The establishment of branch societies of mental hygiene in each county with purposes similar to those of the State Mental Hygiene Association, through which the latter would operate in disseminating information and which would work locally in aiding into putting into operation the above outlined principles and aims.
7. Reorganization of the Department of Public Welfare, looking toward the establishment of divisions of administration, of social welfare, of mental hygiene, and of correction, each under a chief protected by civil service and chosen on merit with rigid specifications embodying professional training and experience.

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Accidents and Children

Fatal accidents ranked first as a cause of death among school children between the ages of 5 to 19 years in Ohio for the year 1931. Every fourth death in this age classification was due to an accident. The automobile was the killer in this group. One out of every 2.3 accidental deaths was associated with an automobile accident.

The second accident enemy for children was drowning. One in every seven accidental deaths was due to this cause.

Tuberculosis ranks *seventh* as a cause of death in all ages in the state, but *among school children it ranks second.*

During the past ten years 37,896 school children have made the supreme sacrifice of death. The tabulation in the Division of Vital Statistics, Department of Health, shows a reduction of 23 per cent in the death rate during this period of time. In 1922 the death rate was 241.2 per 100,000 population and in 1931, the rate was 184.2.

A few of the important causes of death for this group are tabulated below for 1931, with rates per 100,000 population:

	Age 5 to 19	
	Number	Rate
ALL CAUSES	3517	184.2
Tuberculosis (all forms)	531	27.7
Influenza	118	6.2
Scarlet fever	92	4.8
Diphtheria	72	3.8
Accidents (all forms)	895	46.8
Accidental poisoning by food	10	.5
Accidental burns	66	3.5
Accidental by firearms	53	2.8
Accidental falls	40	2.1
Railroad accidents	52	2.7
Accidental drowning	131	6.9
Automobile accidents	384	20.1

The Hospital Health Service of the Nurse in Training

Willard C. Stoner, M.D.* and Robert Reading,† M.D., Cleveland, Ohio

PUBLIC health demands that greater attention shall be given the health of the student in college, which is especially true of the nurse in training, who is so continuously in contact with infection in one form or another. Added to this hazard, are the strenuous hours of work and possible lack of entirely satisfactory living conditions, particularly from the standpoint of regulated exercise and diversion. Health services have been established not only in colleges, but in the larger hospitals throughout the country. The importance of this health work is being generally recognized and argument for the need is no longer necessary. No more striking example of the lack of the proper application of preventive and corrective medicine could be had than that revealed by the examination of the conscripted soldier in the World War.

In no field of work is good health and a good physique more necessary than in the field of nursing. No nurse should be trained for bedside nursing who is not psychically and physically well. No one can very rationally argue for ill health on the part of the nurse in order that she have a better appreciation of health or that she have a more active interest in health measures. Such an experience on the part of a nurse or a doctor ought not to be necessary to create an interest in disease prevention. It is only in recent time that the health of the student nurse is being given more careful attention on the part of the hospitals who receive students for training. The health hazard of the nurse has been emphasized by certain Life Insurance companies that have discontinued issuing disability policies to nurses. Surveys have shown the incidence of tuberculosis to be higher in nurses than in the general population at a similar age. Economically it is important that the nurse be kept well, and from the standpoint of being an apostle of good health it is equally important.

The interest manifested in the nurse's health is bringing better nurses' homes, better hours of work, and more consistent effort is being made to safeguard her health after admission. Hospitals are appreciating their responsibility to the public in general health measures; their responsibility to the patient who is cared for by the nurse. The internal economy of the hospital is affected if there is an undue amount of illness on the part of the nurse from the common cold to tuberculosis. Preliminary physical examinations should be made by a qualified member of the staff before the nurse completes her application for admission and is taken as a preliminary student. This examination must be made standard and generally is not satisfactory when done by the family physician. This examination will eliminate certain undesirable students who, for various reasons, the hospital should not take the responsibility of training. It is a question of individual institutional policy how much responsibility the hospital can afford to take in corrective measures so as to make the applicant acceptable. A more searching examination should be made after the student is taken on as a preliminary student. This examination should be complete from the standpoint of physical, laboratory and special examinations. Immunization tests should be done, such as smallpox, Schick, Dick, and typhoid. Most student nurses who have not had tonsillectomies encounter trouble from the standpoint of throat infections, therefore it is advisable to have the tonsils removed before admission, even though there is no history of throat infection..

It is important to have appropriate records for hospitalization and sick call. It is important to have a fixed morning sick call and at other times in the day as emergencies require. A nurse must be regarded either well or sick and should never be hospitalized in her living quarters. Early hospitalization is important, not only from the standpoint of prevention of dissemination of an infectious condition, but from the standpoint of cutting short an illness. Too little attention is given the handicap that the nurse encounters who is subject to migraine, dysmenorrhea, or high degree of flat feet. Proper living conditions, more attention given recreation and health measures, no doubt, would lessen the incidence of illness in the student nurse.

The occurrence of communicable diseases such as scarlet fever, diphtheria or tuberculosis in the nurse should represent a faulty application of preventive medicine. I believe, that aside from immunization tests, that an *X*-ray film should be a yearly routine on every nurse in training. It is obvious that such a check requires careful clinical interpretation and may easily lead to erroneous conclusions. Observation has shown that reinfection of tuberculosis is common even where there has been childhood exposure. The large general hospital that does not presumably take open tuberculosis, no doubt, offers a real risk to the nurse where the disease may be unrecognized and necessary safeguards are not taken. Syphilis represents a hazard to the nurse as well as the doctor. I have known of a number of instances

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where infections have been transmitted innocently.

The nurse's chief objective is health, therefore she should practice and teach the fundamentals of personal hygiene as concerns rest, fresh air, sunshine, correct diet, even good manners such as in coughing and expectoration.

The importance of early and regular sick call and early hospitalization of illnesses of the nurses in training at Saint Luke's Hospital has demonstrated the advantage of such a routine. No nurse is permitted to medicate herself even for what may appear to be the most trivial ailment. A regular sick call is held daily, supervised by a member of the teaching staff. A nurse is regarded either sick or well, and if sick is routinely hospitalized for the most trivial condition such as an acute rhinitis or common cold. She is not permitted to remain in her quarters when ill. A special blank form is used on sick call which is carried with the bedside record of hospitalization. The general responsibility of all illnesses is carried by the physician to the training school. It is obvious that nurses' illnesses even though representing specialties, should have the general responsibility carried by the physician to the training school. Such a plan obviates defaulting of professional and nursing care if the responsibility is not divided.

It may be of interest to briefly analyze the illnesses of the 200 nurses in training over a period of one year, March, 1931 to February 29, 1932. All nurses have been subjected to Schick, Dick tests, and immunization against smallpox. Immunization against typhoid is not made compulsory and has not been carried out as a routine.

Major surgery in this period consisted of one cholecystectomy, two appendectomies, one ovarian cyst, one mastoidectomy, one repair of femoral hernia. Minor operations consisted of thirteen tonsillectomies and nasal graft following septal abscess. There were two sub-mucous resections, one adenoidectomy, and one removal of ingrown toe-nail.

One case of diphtheria occurred while on contagious service in spite of previous immunization and was Schick positive four months after immunization. Through an oversight, further administration of toxin-anti-toxin was not given. At the present time four doses of goat toxin-anti-toxin are given for routine immunization of positive Schick cases.

Five cases of scarlatina occurred while on service at Saint Luke's, and five cases while on service in an affiliated contagious hospital service. Of this group, seven were Dick negative and three Dick positive. Of the three Dick positive, one had finished her third of five immunizing doses when she contracted scarlet fever. The second positive reactor had had five immunizing doses several months earlier and contracted scarlatina while on contagious duty. The third positive had not yet been given toxin-anti-toxin and contracted the disease while on contagious duty.

Three of the five negative Dick tests at Saint Luke's Hospital had been checked at a one year interval by different doctors whereas the remaining two were positive one year ago but negative on the last test. Of the five cases occurring at the contagious hospital, three had repeatedly negative Dick tests. These figures vary considerably from those of one observer who reported 3,162 Dick negative doctors and nurses, none of whom developed scarlet fever after repeated exposure.

For active immunization against scarlet fever, we have followed the recommendations of the scarlet fever committee using five weekly doses consisting of 500, 2000, 8000, 25,000, and 80,000 skin test doses respectively. In 31 Dick positive students, 22 had local reactions to the first injections consisting of local redness and tenderness. Following the second dose, 22 had local reactions and two were hospitalized. After the third dose 19 had local reactions, six had scarlatiniform rashes and required hospitalization, four of the six complaining of joint stiffness. The fourth dose caused 24 local reactions and two hospitalizations. The fifth dose caused 22 local reactions and seven hospitalizations. The total number of days lost during reactions to the scarlet fever toxin were 47, of which five students were responsible for 25 days. The average hospitalization was 2¼ days for the 21 girls admitted, one girl being admitted three times and five girls—twice. Of 51 Dick positive tests 46 were negative after five immunizing doses. Inasmuch as 10 per cent of all ordinary exposures are supposed to contract the disease and 50 per cent of all intimate prolonged exposure acquire scarlet fever, we believe that early Dick tests with immunization is advisable in spite of the reactions provoked.

Days of hospitalization from month to month showed a marked variance. March, 1931, when there was quite an epidemic of influenza, there were 230 days of hospitalization by 26 nurses, represented largely by acute upper respiratory tract infections. There were two cases of arthritis and one of diphtheria. April was represented by 168 days of hospitalization on the part of 17 nurses.

It is of interest to note that the days of hospitalization lessened from month to month through the summer season. Two factors contributed, fewer upper respiratory tract involvements, vacation time and added recreation. June was exception by reason of a nurse who was taken ill with scarlet fever and a number of exposures required hospitalization isolation.

There were 11 nurses hospitalized in August

with a period of 36½ days hospitalization. Five were due to gastro-enteritis.

The November incidence was raised by a recurrence of upper respiratory tract trouble and a number of rather severe reactions to Dick serum.

December showed a low incidence of illnesses, hospitalization largely resulted from Dick serum injections.

January showed an increased incidence of acute respiratory tract trouble, but no definite influenzal manifestations.

The February incidence was largely due to influenza in mild form without complications and represented by short periods of hospitalization. Interestingly, leukocyte counts done routinely showed a leukopenia below 5000 in most cases.

A review of the illnesses shows comparatively few days of hospitalization on account of dysmenorrhea or sick headache, which emphasizes the importance of carefully selecting the student for training. Nervous fatigue and maladjustment to the work are always difficult problems. Four cases of pulmonary tuberculosis have arisen during the year, all of which developed insidiously and serve to emphasize the importance of careful health checks, and hospitalization of illnesses representing fever or symptoms of consequence. It is important to have *X*-ray films of the chest as a yearly routine.

SUMMARY

To summarize our experiences, the following conclusions are warranted:

1. Utmost care in selecting the student for training.

2. Daily sick call and early hospitalization is desirable, not only from the standpoint of lessening illnesses, but serves as a splendid demonstration of the value of preventive measures.

3. Our experiences with immunization against scarlet fever and diphtheria leaves us with an unsettled point of view as to the value of the absolute immunization against scarlet fever.

4. More careful study of all chest cases hospitalized to avoid overlooking a proper diagnosis of a chest condition, and effort to recognize tuberculosis early in the nurse which must mean the advantage of a routine *X*-ray film.

5. Nurse should have instruction early in her training in preventive medicine and public health.

6. Tonsillectomies should be done as a routine to avoid and lessen infections such as scarlet fever, diphtheria and Vincent's angina.

7. The incidence of acute illnesses in the student nurse in a large hospital represents a good index of the occurrence of illnesses in the general population characterized by epidemics such as influenza and the seasonal variations of acute diseases.

8. It is obvious that the nurse in training should have advantage of ideal living conditions, proper recreation and rest, if she is to be kept efficient in the work of training and caring for the sick.

1608 MEDICAL ARTS BUILDING.

DISCUSSION

LEE H. FERGUSON, M.D., Cleveland: Dr. Stoner has so admirably covered the subject of the health problem of nurses that it hardly seems that much more can be said. However, as the care of the nurses at the University Hospitals in Cleveland is tied up with the Western Reserve Health Service, it may be that I can present the essential facts in a slightly different light. We regard the student nurses as a part of our student body and they receive the same care and attention which are given to other University students. It is to be admitted, however, that as the nurses come in direct contact with sick people on the wards and are subjected to unusual strains, they present some problems which are not found in other college students. The problem can be divided into about three parts. First: *The careful selection* of applicants applying for admission. Second: *Careful history* and thorough examination on admission. Third: *Care while taking* the nursing course.

I will try to cover these three essential points as we view them at Western Reserve. I will not touch on the contagious disease problem as this will be covered later by Dr. Toomey.

All applicants for admission to the School of Nursing are required to have a preliminary examination by their family doctor before coming to Cleveland. They are also required to be vaccinated against smallpox and typhoid fever. We have been in the habit of immunizing the students against diphtheria and scarlet fever after their admission.

It has been our experience that the examination done by the family doctor must be considerably discounted and can not be taken at its face value. Often, however, these examinations give us clues which, when carefully investigated, may result in the rejection of the applicant. If the home doctor knows that we seriously question a certain condition and ask for a definite report on it he is much more likely to give us all the facts than he is on a general examination. For instance, recently an affiliating nurse was applying for admission to service at Maternity Hospital and Babies' and Children's Hospital. Her doctor reported chronic otitis media. In spite of this, however, he did not hesitate to recommend this nurse for admission. When he was advised that we could not under any condition admit a student with a discharging ear to either one of these hospitals and we suggested that the mastoid be *X*-rayed and possibly the tonsils removed in order to clear up this condition, the application was promptly withdrawn. It is our surmise that this ear will be given vigorous treatment and the discharge cleared up. In case the conditions are serious enough, the applicant is required to apply in person and a preliminary physical examination is made before she is accepted.

Of course, there are some conditions, both physical and mental, which can not be detected by physical examination and so there are always sure to be some candidates who will be dropped at the end of their probation period. I have reference here particularly to those who have unstable nervous systems and lack of balance which would definitely disqualify them for nursing as

a profession. Nursing training at best is a hard grind and should not be undertaken by those who lack the initiative, vigor and poise to carry on in a trying situation.

From the figures which I will present later relative to upper respiratory infections we have about reached the conclusion that practically all nurses who enter training would be better off if their tonsils were removed prior to admission. At least a careful check-up has shown that those nurses with tonsils removed are much less likely to suffer from nose and throat infections than those who still have their tonsils. It is rather difficult, however, to get this done as even when we suggest it to the family doctor he will report that he does not regard it as necessary. Then we have watched this same applicant go on duty and perhaps in four or five months suffer from a nose and throat infection and it is necessary for us to remove the tonsils. The above is merely an impression and the problem of tonsils should be more carefully studied over a period of years before any definite conclusions can be drawn.

As tuberculosis in nurses is still a major problem it is our feeling that all applicants who are tuberculosis contacts or supposedly arrested cases should have films made just prior to their admission. These films should be carefully gone over by the doctor who has charge of the nurses before they are accepted. Recently I had an applicant who as an arrested case had been previously rejected because she had not been out of the sanatorium long enough. Subsequently her condition was certified as satisfactory by her doctor, but an *X*-ray taken immediately upon her arrival showed a definite spread of the disease in one lung and she was promptly sent home with the recommendation that she resume her rest treatment. All contact cases are given lung examinations every four to six months; are *X*-rayed yearly and watched carefully during upper respiratory infections.

In the second place, after an applicant has been accepted she should have, on admission to the school, a complete history taken and a thorough physical examination. It is generally felt now that a Mantoux intradermal tuberculin test is desirable in all students. The initial dose suggested is 1/100 of a milligram, and if this is negative then a one milligram dose can be given. All positive cases should have chest *X*-rays and all negative cases should be re-tested in six months to one year.. The value of this latter procedure has been definitely proved by Dr. Myers at the University of Minnesota. He has found, for instance, that a nurse who has changed from a negative tuberculin to a positive tuberculin reaction was taking care of a case on the wards that was supposed to be bronchiectasis that later was proved to be tuberculosis.

Although we have not yet started tuberculin testing at Western Reserve we have this year made flat chest films on all of our entering nurses. Out of 93 cases we found twenty cases which showed calcified areas representing healed childhood tuberculosis; that is 21½ per cent. In this particular group we found no cases of parenchymatous infiltration..

If tuberculin testing is not done, then it is my feeling that every student should have a flat film as a part of their entrance physical examination.

Whether or not it is desirable to do a routine Wassermann on all entering nurses is somewhat of a question. Dr. Diehl of the University of Minnesota has found that in the average student body one positive is found in about every 500 examined. In the last five years we have had one case of neurosyphilis in a nurse which was picked up by pupillary reaction.

It seems probable that if applicants are carefully selected before admission to the school and that those who are accepted have a complete history taken and a thorough examination made, that we have done about as much as is possible to insure the physical fitness of those who study nursing.

Lastly, while a nurse is on duty there are certain definite procedures which can be instituted to lessen the time off duty. Of course, in spite of all precautions there will still be occasionally nurses who will pick up serious conditions. There will be occasional cases of rheumatic fever, appendicitis, pneumonia and other less frequent conditions. These I do not think can be prevented to any great degree and the problem they present is entirely one of adequate care in the hospital. Our attention, therefore, should be directed to those minor illnesses which either can be prevented entirely or else can have the time off duty materially lessened. We have demonstrated, for instance, that in the case of common colds that if the nurses are at once taken off duty that the time necessary to effect a cure can be very much reduced. In addition, the serious complications may be prevented.

The tabulation of the results for a single year may help to illustrate some of these points. In the year 1929-30 we had a total of 940 days illness in our nurses, representing 205 cases. In this 940 days there were 50 days represented by a case of tuberculosis; and 150 days by a case of rheumatic myocarditis. It is doubtful if either of these could be prevented, so they should be taken from the total of 940 leaving a balance of 740 days illness (79 per cent) which might be prevented.

Of these 740 days of preventable illness 346 days, 46 7/10 per cent. representing 79 cases were due to upper respiratory infections. This number is 37 per cent of the total for the year which is slightly lower than the 40 per cent reported by Dr. Lee Shrader of St. Louis.

The next largest group was 93 days, 12½ per cent, representing 24 cases classified as gastro-interstinal upsets; 77 days of 10 4/10 per cent, representing 22 cases, were due to local infections, fingers and so forth; 59½ days, 8 per cent, representing 13 cases, were due to operations including tonsils and appendix; 24 days, 3 per cent, representing 4 cases, were due to gynecological conditions including dysmenorrhea; 21 days or 2 8/10 per cent, representing 2 cases, were due to contagious diseases.

The remainder of days off duty, total 119½ or 16 per cent, represents miscellaneous conditions including injuries, skin trouble, reactions to vaccine and so forth.

If we combine 346 days, upper respiratory infections, 93 days, gastrointestinal upsets, 77 days local infections, 24 days gynecological, and 21 days contagious diseases, we have 561 days, 60 per cent of the year's total, which probably represent the great bulk of our preventable illnesses. As mentioned above, the days off duty on account of upper respiratory infections can be materially lessened by having tonsils removed prior to admission and by putting the nurses to bed as soon as symptoms develop. Gastro-intestinal upsets probably can be materially lessened by more care to diet and local infections by instructing the nurses in technique. Twenty-four days due to

gynecological conditions can probably be materially lessened by putting all of these cases under proper care when the first symptoms develop.

In addition to the care of the sick nurses it is my opinion that in order to maintain the health of nurses that they should be given the same privileges for recreation as other students are given.

At Western Reserve we have a full time Director of Physical Education in our Nursing School and the nurses are given physical education work three times a week during their first four months. After they enter the hospital for their clinical work they have an opportunity for team work in basket ball, tennis and other sports. Unfortunately, this has not been developed to its maximum and it is my feeling that an active program of physical education for all three years of nursing training would be well worth while. The time is not far distant when all hospitals will be constructed with adequate physical education facilities, including gymnasiums, tennis courts and swimming pools.

To sum up, then, we can say that if nurses are carefully selected for admission, have a complete history and physical examination upon enrollment and if they are given adequate care for minor illnesses which constitute the chief cause for being off duty, much good can be accomplished. Furthermore, an active health program for the nurses in physical education should be instituted.

JOHN A. TOOMEY, M.D., Cleveland: This paper recalls to our mind an experiment carried out by us some ten or eleven years ago when we were in medical charge of a large nurses' training school. At that time, the hospital days the nurses were ill averaged so high as to nearly cripple the service. After some thought, we put into effect the following rules:

1. Any member of the hospital training school who develops an illness, no matter how trivial, is to be admitted to the hospital at once.

2. No nurse, student or graduate, shall be treated for any disease in the dormitory or rooms of the nurses' residence.

The results were astonishing. The number of nurses admitted to the hospital increased enormously, but the number of hospital days these individuals were ill was decreased by over 50 per cent.

Our actual discussion of today's paper centers about a consideration of some of the methods that are directed toward the prevention of contagious diseases. It is unnecessary to consider chickenpox, mumps and many other of the contagious diseases because there is nothing that can prevent the disease in a susceptible after exposure. We will confine our remarks to the control of smallpox, diphtheria and scarlet fever.

At the onset, we might say that, unlike the speaker, we feel that every nurse and doctor should be given typhoid-paratyphoid injections. Perkins has observed that the immunity of vaccinated individuals wears off and thus we may infer that these injections would have to be repeated every three or four years.

Everybody should be vaccinated against smallpox. There may be individuals who have natural immunity against this disease but they are so few in number from a mathematical standpoint that it is wise to consider nobody protected unless they have had the disease or an actual vaccination take. The fact that a person has been vaccinated many times does not mean that the individual is protected. We have seen nurses who have been vaccinated frequently,—one in particular, fourteen times—who, nevertheless, have contracted the disease. Individuals who have been successfully vaccinated should be re-vaccinated if re-exposed to smallpox within five or six years after their successful vaccination take. The majority of successfully vaccinated individuals have some permanent protection, but because of the few who lose their immunity, it is necessary to play safe and revaccinate everyone who has subsequent intimate exposures after the time period noted above. If the individual is still immune, there will be naught else than a local reaction of immunity, while the individual who has lost protection will have the needed retake.

In diphtheria, there is no doubt about the efficient protective value of toxin-antitoxin. We have used this material for years and had become aware of the sensitizing action of the horse serum in the toxin antitoxin mixture and were glad to switch to the newer toxoid for our immunizing material. We are using this product for active immunization and get a greater percentage of immunes sooner than occurred after toxin-antitoxin injections. It was the consensus of opinion in the discussion at the recent meeting of the public health officials in Montreal that diphtheria toxoid had proved its value and was probably the better of the two mixtures to use.

In scarlet fever, we immunize all nurses who have positive Dick tests in the manner and according to the method recommended by the Dicks. We have injected over 1,000 Dick positive susceptibles and unlike the speaker we have had no one who has been sensitive, who has been completely immunized with the five injections, who has developed the disease. There were numerous reactions noted during this active immunization program and with certain individuals we had to cease injections because of the sensitivity revealed. After these immunizing injections, we have seen reactions all the way from early thermic responses, thermic responses with urticaria and edema, local skin reactions and local indurations and edema, sometimes swelling of the entire arm and incidentally many rashes. The procedure is valuable for those exposed intimately to scarlet fever in their daily work, but we feel that we are not justified as yet in adopting this procedure as a public health measure.

KARL G. ZWICK, M.D., Cincinnati: If the preliminary routine physical examination, which, as Dr. Stoner has shown us, is so valuable for the detection of various defects, were supplemented by a cutaneous tolerance probe, it would serve to reveal an existing sensitivity. I am prompted to make this suggestion, as from time to time I have occasion to observe student-nurses who are seriously handicapped in their course of training because they are supersensitive to one or more substances with which they come in contact in their work.

As the various antiseptics and disinfectants (including denatured alcohol) are, in my experience, most frequently the eczematogenic agents, it might be an advantage to determine the skin's resistance *to* or tolerance *for* these chemicals in those nurses at least whose history records a previous dermatosis.

(I will add, in passing, that my suggestion **ap-**

plies also to medical students and, particularly, to internes who intend to specialize in surgical work.)

In regard to the importance of re-vaccination I share Dr. Toomey's views. The protective immunity conferred by inoculation diminishes gradually, so that in time the body can no longer resist a massive infection, hence the necessity for *re*-vaccination. But the course of smallpox in a successfully vaccinated individual is relatively mild, even though years have elapsed since the vaccination; thus the reason for vaccination.

The conditions of allergy, immunity and diminution of immunity in smallpox apparently are analogous to those in syphilis where infection is also followed by allergy, immunity and its diminution and at times super-infection (not *re*-infection) by massive inoculation.

However, super-infection in syphilis is attributable, according to some investigators, to inoculation with an allo- or hetero-tropic virus (i. e., neuro- or dermato-tropic spirochaete). Of course, in syphilis we have so far no prophylactic inoculation notwithstanding many attempts in the past, or the recent ones of Lancelotti and Jaureguys. Whether there is more than one recognized strain of smallpox virus, I do not recall at the moment.

Avulsion of the Tibial Tubercle

LUKE V. ZARTMAN, M.D., and A. SOPHIE ROGERS, M.D., Columbus, Ohio

AVULSION of the tibial tubercle was first described as a definite pathological entity by both Osgood and Schlatter in original monographs in 1903. Since that time, it has been known as Osgood-Schlatter's Disease. It is also known as acute epiphysitis, periostitis tibiae, and apophysitis tibia.

The tibial tubercle develops from a tongue-like projection of the lower and anterior aspect of the ephiphysis. Ossification between this and the diaphysis takes place some time between the twenty-first and the twenty-fifth year. Thus union takes place after the period of greatest activity.

This condition develops in adolescence from ten to sixteen years, most frequently in the thirteenth or fourteenth year and usually in boys. The New York Hospital for Ruptured and Crippled reported one woman of 41 years. Almost invariably a history of trauma is present, such as a blow over the tubercle or a strong contraction of the quadriceps femoris, the latter condition being found often in athletes. Thus, it may be seen, as a result of a blow or a strong pull, that the epiphysis which is not firmly united to the diaphysis may be torn loose; in later life, the same factor may cause a fracture of the patella. It has, however, been noted after low-grade infection and in children with definite rachitic changes.

The Hospital for Joint Diseases of New York reports this condition presents in .7 per cent of knees examined, being bilateral in 25 per cent of above cases. The Cincinnati General Hospital reports one case in six years. The New York Hospital for Ruptured and Crippled reported six cases from October, 1916, to April, 1917. The case being reported is the only one that our hospital records show.

The pathology differs in traumatic and infectious cases. In traumatic cases there is present a more or less complete avulsion of the tip of the epiphysis. In the infectious cases, a non-suppurative, subacute inflammatory hyperplasia of the tubercle is present. We have not found any suppurative cases reported. There is present a thickening of the surrounding tissue in either case, so that with the avulsion or the infection, there tends to be considerable enlargement of the tubercle present.

The patient complains of pain around the tibial tubercle. This is low-grade, dull, and aching in character, which is exaggerated by exercise.



(1) Left tibia. Notice the fuzzy moth-eaten appearance with definite infiltration about tubercle.

There is a limitation of motion present, which is variable, but without a complete loss of function. This limitation is essentially an inability to completely extend the leg. This is more marked after rest, while after slight use, it is not so apparent or may even disappear. Periarticular swelling is

From the St. Francis Hospital, Surgical Department, Ohio State University.



(2) Right tibia. Notice normal appearing tubercle with epiphysis not attached entirely.

present but never to the extent to obliterate the normal landmarks. Pretibial swelling and tenderness are present due to the avulsed edge or the inflammatory reaction. Diagnosis is made from the history, symptoms, and *X*-ray findings; the latter is pathonomonic. When due to simple avulsion, it shows early the torn edge lifted up, with later a filling in of this defect. Early infection shows a fuzzy, moth-eaten, low-grade inflammation; later, proliferation with disappearance of the cartilaginous margins.

The complications are those of synovitis, extravasation of blood into the surrounding tissues and periarticular swelling.

This condition is to be differentiated from sarcoma, tuberculosis, syphilis, osteomyelitis, bone cysts, etc. The *X*-ray gives the final diagnosis.

The prognosis is good. These cases always get well but leave a definite enlargement of the tibial tubercle.

Treatment consists in immobilization. This varies from local strapping with adhesive to plaster-paris casts and rest in bed from six weeks to three months. No doubt, one is guided by the severity of the local condition and the response of the individual to treatment. After the removal of the cast, heat, massage, and mobilization should be instituted. In the severe avulsed cases, it may be advisable to make an open operation and fix the fragment.

CASE REPORT

R. V.—white boy, 14, student, presented himself with a history of having received a severe bump over the left tibial tubercle one year previous. He had had pain persistently over this area since, being exaggerated by exercise. After rest, there was stiffness present, but "limbered up" after use and did not interfere with locomotion unless he walked a great distance. The tibial tubercle has been gradually enlarging. Tenderness was present.

Examination showed a normal appearing boy with a slight limp. Locally, there was a definite, smooth enlargement of the tibial tubercle. There was slight roughening present and tenderness on pressure. *X*-ray, taken by Dr. H. F. Fulton, St. Francis Hospital, showed a definite enlargement of the tibial tubercle with the characteristic fuzzy erosion present.

Limited mobilization was permitted with instructions to apply heat twice a day. Courses of potassium iodid were given. At last report, pain and tenderness around part had greatly decreased and the boy is a great deal more active.

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Malaria Still Prevalent

Not many years ago malaria was so extremely prevalent in Ohio that few individuals could boast of having escaped its ravages. It was popularly known as 'fever and chills" and as "ague", and countless thousands of citizens alternately burned with fever and froze with chills, became weakened physically and mentally, and died if the malaria parasite destroyed a sufficient number of red corpuscles to prevent their vital functions.

While no longer a major health problem in Ohio, there are always reported a few sporadic cases of malaria, and the case mortality rate is fairly high.

The *anopheles* mosquito is indigenous in this state and a flare-up can occur wherever case and mosquito meet.

The relative rarity of this disease in Ohio in recent years, and the relatively high mortality rate, are shown in the following ten-year table:

Year	1922	1923	1924	1925	1926	1927	1928	1929	1930	1931
Cases	51	22	14	17	17	21	32	47	55	32
Deaths	11	4	6	9	9	3	5	4	7	6

The once popular belief that night air, more especially that in the vicinity of swamps or stagnant water, caused malaria, had something of truth, because malaria-bearing mosquitoes breed in stagnant water and generally do their damage after nightfall; the present widespread belief that mosquitoes cause the disease is still nearer the truth, for the mosquitoe is an essential in the spread of malaria.

Mosquitoes, however, do not cause malaria; they carry it from infected to healthy persons, and not all species are guilty of doing this.

The President's Page

A Personal Communication to the Membership from

H. M. Platter, M.D., Columbus, Ohio

Medical organization is concerned with the obligation of keeping the practitioner in the field abreast of the time in order that he may make an individual contribution to public welfare. It is also concerned in seeing that members so equipped will be guaranteed economic security sufficient in amount to enable the individual practitioner to discharge his duties.

The county medical society is the unit of medical organization. Its officers and committees should be alert to protect the individual practitioner against socialistic incursions which will destroy his ability to make a living.

Of recent years there has crept into our life a desire on the part of the public to interest individuals in the welfare and care of one another. So long as this urge is restricted to the care of indigents such awakened interest is laudable, but when by devious means clinics of all sorts are promoted which care for the individual at a reduced rate and thereby tend to pauperize the individual practitioner of medicine, a very great harm results. This question should receive the thoughtful and careful consideration of each medical society. We can not do our best work with an empty purse and an empty stomach. In our frenzied effort to supply charity we must not forget ourselves. We must not aid and abet any movement, however well organized, which will contribute to such results.

No body of men in season and out of season makes the contributions in service to the public as do the practitioners of medicine. No charitable organization or clinic can continue without our aid. They must be brought to see that in order to discharge their altruistic purposes and dreams that they must not pauperize us. Component societies should carefully study this problem and insist that the individual practitioner of medicine shall not be lost sight of during this period of economic collapse. Retrenchment is the order of the day in business and in government.

The practitioner has no commodity for sale other than service. No doubt, this service must be made available at a lower rate than during prosperous times, but it should be regarded as a commodity and reckoned with in any scheme promulgated to take care of our people.

So-called fact-finding commissions have almost been a bane of our existence during the past decade. Their reports are readily available and the amount of money freely given in services by practitioners can easily be computed. Such services are of infinitely greater value to the community than agencies which have been supported by our community charities.

It seems that our business in the immediate future will be to take care of the sick and suffering first. Our members should not give support and service to organizations in competition with the physician in private practice.

High Standing of Medical Education in Ohio Shown by Record Number of Students and Splendid Educational Facilities in Ohio's Three Class A Schools at Start of New College Year

Evidence of the increasing importance of Ohio as a medical educational center is found in data and statistics concerning Ohio's three Class A medical schools—School of Medicine, Western Reserve University, College of Medicine, University of Cincinnati, and College of Medicine, Ohio State University—as they resumed classes for the 1932-33 school year.

The total enrollment of the three schools was 969, an increase of 50 over the aggregate enrollment at the beginning of the 1931-32 school year.

This enrollment, divided as to classes, was: Seniors, 225; juniors, 220; sophomores, 245, and freshmen, 269. Divided as to schools, the enrollment was: Western Reserve, 279; Cincinnati, 322; Ohio State, 368, compared to total enrollments of 258; 306 and 355, respectively, in the previous school year.

A number of significant facts are revealed by analysis of these figures and additional data compiled by executives of the three Ohio schools at the beginning of this academic year, and by a comparison of the Ohio statistics with those assembled by the Council on Medical Education and Hospitals of the American Medical Association on the nation as a whole.

In the last report of the A.M.A. Council on Medical Education and Hospitals, published in the August 27, 1932, issue of *The Journal of the American Medical Association*, it is pointed out that there is a nation-wide trend toward a substantial increase in medical school enrollments, a fact borne out by the Ohio figures.

Figures for the academic year 1931-32 show that enrollments in 76 approved medical schools totaled 22,135, an increase of 153 over the year 1930-31, and the largest enrollment since 1905 when 26,147 students were in attendance at 160 medical schools. The report predicted that the present academic year would witness a further increase in medical school enrollments.

Commenting on this factor editorially, the *A.M.A. Journal* refers to it as "one of the most serious problems now confronting our profession".

"The United States already has more physicians in proportion to its population than any other country in the world", the editorial states. "If this ratio is still further increased, it is evident that an oversupply of doctors threatens, with an inevitable lowering of the standards of the profession."

However, it is pointed out that a part of the increase in the actual number of physicians is due to the return to this country of students who have taken work in European schools after having been refused admission to American medical schools.

That this national problem of a possible oversupply of physicians may sooner or later become acute in Ohio is indicated by the fact that there has been a steady growth for a number of years in enrollments and in the number of graduates in Ohio's medical schools. Although the increases over a period of years have been small and hardly more than enough to meet the demand for a greater number of well-trained physicians, the trend in Ohio, like the nation generally, is apparent and forecast that those in charge of medical education administration in Ohio may in the near future be faced with the necessity of placing even more strict limitations on enrollments.

The total enrollments in the three Ohio schools for the past seven years, including the present academic year, have been:

1932—969
1931—919
1930—873
1929—839
1928—841
1927—846
1926—825

The total number of students graduated by the Ohio schools over the same period was:

1932—193
1931—194
1930—176
1929—192
1928—204
1927—150
1926—188

A comparison of the number of students graduated annually by the three Ohio schools with the number of new students enrolled reveals that an unusually large percentage of students continue to graduate and eventually locate in Ohio.

The foregoing figures indicate that Ohio's medical schools are faced with the same problem as all the medical schools of the country, that of keeping their output compatible with the need for new physicians. At the same time they reveal the high standards maintained at these schools and the high regard held for them by students seeking a medical career.

The fact that each of the Ohio schools annually is confronted with the task of selecting new students from lists of applicants sometimes approximating 1000, indicates that enrollment in an Ohio school is much sought after.

The data, moreover, is proof of the high quality of the work given by each of the three Ohio medical schools; the care used in the selection of new students, and the serious effort made to keep en-

rollment and graduation figures balanced. Each of the Ohio schools has an extremely low "mortality" among upper classmen and the percentage of all classes repeating course is being held to a minimum.

Another significant fact is that almost all of the graduates of the Ohio medical schools finish out their training with a hospital internship.

While figures are not available now for those who were graduated last June, out of a total of 196 graduates and fifth-year students in 1931, 195 entered hospital internships.

The importance which graduates of the Ohio schools place on intern training follows a nation-wide trend in this direction. The last report of the A.M.A. Council on Medical Education and Hospitals shows that 4735 out of a total of 4936 medical school graduates in 1931 entered internships. There are at present 696 hospitals in the nation approved by the Council for intern training, offering 6154 internships. The fact that there are considerable more internships offered than the number of medical graduates annually has created a problem for many hospitals.

Two experiments which may result in a partial solution to this problem are now being tried. One is the extension of the period of intern service to fifteen or eighteen months, resulting in a greater spread of interns. Another is the practice of arranging for intern service at different times during the year, so that there always will be a few experienced interns in whom confidence can be placed while the new group is becoming accustomed to new duties and hospital methods.

Ohio is amply supplied with hospitals approved for interns, in fact the 36 Ohio institutions which have been approved by the A.M.A. Council offer 328 internships, a figure considerably larger than the number of graduates from the three Ohio medical schools.

The Ohio hospitals which have been approved for interns and which have an aggregate bed capacity of 12,075 are:

Akron City Hospital
St. Thomas Hospital, Akron
Mercy Hospital, Canton
Bethesda Hospital, Cincinnati
Christ Hospital, Cincinnati
Cincinnati General Hospital
Deaconess Hospital, Cincinnati
Good Samaritan Hospital, Cincinnati
Jewish Hospital, Cincinnati
St. Mary's Hospital, Cincinnati
Charity Hospital, Cleveland
Cleveland City Hospital
Mount Sinai Hospital, Cleveland
St. Alexis Hospital, Cleveland
St. John's Hospital, Cleveland
St. Luke's Hospital, Cleveland
University Hospital, Cleveland
Woman's Hospital, Cleveland
Grant Hospital, Columbus
Mount Carmel Hospital, Columbus
St. Francis Hospital, Columbus
Starling-Loving University Hospital, Columbus
White Cross Hospital, Columbus
Miami Valley Hospital, Dayton
St. Elizabeth Hospital, Dayton
Elyria Memorial Hospital
Mercy Hospital, Hamilton
St. Rita's Hospital, Lima
Springfield City Hospital
Flower Hospital, Toledo
Lucas County Hospital
Mercy Hospital, Toledo
St. Vincent's Hospital, Toledo
Toledo Hospital
St. Elizabeth's Hospital, Youngstown
Youngstown Hospital

Students permitted to enter the three Ohio medical schools must have had their premedical training in an accredited or approved college of arts and sciences or junior college.

Ohio is well supplied with approved colleges of arts and sciences and junior colleges in which Ohio students may obtain their premedical training. In addition to the colleges of arts and sciences of the three universities of which the Ohio medical schools are a part, the following schools have been approved by the Council on Medical Education and Hospitals of the A. M. A. as offering satisfactory premedical training:

Antioch College, Ashland College, Baldwin-Wallace College, Bowling Green State College, Capital University, Case School of Applied Science, College of Mount St. Joseph-on-the-Ohio, Wooster College, Denison University, Heidelberg College, Hiram College, John Carroll University, Kenyon College, Lake Erie College, Marietta College, Miami University, Mt. Union College, Muskingum College, Notre Dame College (South Euclid), Oberlin College, Ohio University, Ohio Wesleyan University, Otterbein College, University of Akron, University of Dayton, University of the City of Toledo, Ursuline College, Western College, Wittenberg College, Xavier University.

Fewer improvements in the physical plants of the Ohio schools than usual were made or started during the past year, primarily because of unsettled business conditions. No radical changes were made in the curriculum of any school. The high caliber of the teaching staffs of each has been maintained, despite the financial crisis, and no curtailments made which will in any way have a detrimental effect on the high standard of the institutions.

Comments by the executives of the schools indicated that the business depression seemingly has had little or no effect on enrollments and that all of the schools are preparing to assist and advise in every possible way students who may find themselves confronted with financial difficulties after the school term has gotten under way.

Following are brief summaries of information and statistics on each of the three Ohio medical schools as the present school year began:

WESTERN RESERVE, SCHOOL OF MEDICINE

Western Reserve University, School of Medicine, opened its 90th year with a student body of 279, the largest enrollment in the history of the school.

Students registered for the academic year 1932-33 totaled 21 more than the registration last Fall, gains being made in all but the junior class. The largest gain was made by the sophomore class, the enrollment for which was 75 in comparison to an enrollment of 62 last year, showing a high ratio of promotions from last year's freshman class.

The following statistics on enrollment and graduation at the school for the years, 1926 to 1932 in-

clusive, show the uniformity in classes which is maintained and indicate the effective methods used in the selection of new students and the all-around high standards set in the classroom work:

NUMBER OF STUDENTS

	1932	1931	1930	1929	1928	1927	1926
Freshman	79	76	75	72	71	73	73
Sophomore	75	62	61	58	60	61	53
Junior	55	62	61	59	60	52	59
Senior	60	58	58	57	52	58	36
	279	258	255	246	243	244	221

GRADUATES

1932	1931	1930	1929	1928	1927	1926
57	58	54	52	58	36	47

These figures reveal the steady growth and expansion of the school to meet the greater demands of students seeking a medical career, as well as the exceedingly low mortality in the student body generally.

There was a slight falling off this year in the number of applications for admission to the first-year class, applications received totaling 607, compared to 644 in 1931. However, the task which confronted those responsible for selecting just a few more than one-tenth of the number of applicants as first-year students is obvious, considering the fact that the great majority of the applicants were persons who had had premedical training in approved colleges of arts and sciences.

Officials of the school anticipate a slight decrease in the total enrollment later in the school year, because of the economic situation. However, the university is doing all it can to help students who have already enrolled to remain in school.

The principal change in the curriculum has been in the fourth year. This had previously consisted of 48 weeks of clinical clerkships of which eight weeks were elective. These electives have now been made optional, allowing greater flexibility. Somewhat over half of the students have enrolled for the optional work.

In spite of the depression, the staff of the school has been kept essentially intact. The two principal changes in the faculty were the retirement to professor-emeritus of Dr. John P. Sawyer, who had served the school since 1889 as professor of therapeutics and clinical medicine, and the transfer of Dr. Elliott Carr Cutler, professor of surgery, to Harvard University where he has become Moseley professor of surgery. A faculty committee has been appointed to name a successor to Dr. Cutler.

Few additions to the physical plant of the school have been made. An anonymous gift of $300,000 has been received to endow the chair of surgery.

Western Reserve University, School of Medicine, was organized in 1843 as the Cleveland Medical College. The first class graduated in 1844. In 1881 the school assumed its present title and in 1910 the Cleveland College of Physicians and Surgeons was merged. It has been co-educational since 1919. The faculty includes 66 professors and 159 lecturers, assistants and others, a total of 225. The curriculum covers three years of eight and one-half months each and one year of nine months Graduation from an approved college or scientific school or equivalent, or completion of a course of at least three collegiate years, is required for admission. The total fees for each of the four years are, respectively, $442, $433, $415 and $425. The dean of the school is Dr. Torald Sollmann.

UNIVERSITY OF CINCINNATI, COLLEGE OF MEDICINE

One of 14 medical schools in the United States which requires a hospital intern year for the degree of M.D., the University of Cincinnati, College of Medicine, opened for the 1932-33 academic year with a record-breaking enrollment of 322. Substantial gains were registered in the sophomore and senior classes, shown in the following figures on enrollment and graduation for the years 1926 to 1932, inclusive:

NUMBER OF STUDENTS

	1932	1931	1930	1929	1928	1927	1926
Freshman	90	90	90	91	78	73	72
Sophomore	82	76	73	73	64	66	64
Junior	75	76	65	61	61	66	65
Senior	75	64	61	58	67	69	67
	322	306	289	283	270	274	268

GRADUATES

	1932	1931	1930	1929	1928	1927	1926
Doctor of Medicine	61	58	64	66	64	56	64
Bachelor of Medicine	67	60	57	65	65	65	

Since 1927, the college has required that all students must complete a year's internship in a hospital recognized for intern training by the Council on Medical Education and Hospitals of the American Medical Association and approved by the executive committee of the medical college faculty before they are eligible for a medical degree.

The college annually is faced with the problem of selecting a comparatively small number of first-year students from a huge list of applicants, sometimes approximating 700 or 800. Data on the number of applications received for the 1932-33 school year is not now complete, but officials at the school point out that there has not been much relief from the pressure which has been felt during the past several years in this respect.

The flood of applications to enter the college continues each year despite the fact that it maintains one of the most effective and most rigorous methods of testing students for admission now in use in the United States This attests to the popularity of the college and to the high caliber of the work given.

All prospective applicants to the college must submit credits after the first semester of their

senior premedical year. During the Spring months, the Committee on Admissions holds weekly meetings to study grades and credits. The final selection of students is made before the end of the second semester of the college year, subject, of course, to the satisfactory completion of second-semester courses. Many of the applicants are under observations for several years during the premedical training. Except in unusual cases no applicant with a premedical grade average of less than 85 is considered by the Admissions Committee. The aptitude test as conducted by the Association of American Medical Colleges is one of the principal criterions for the selection of students, although considerable emphasis is placed on scholarship, personal interviews and confidential letters from instructors and others knowing the applicant.

At the present time a minimum of two years of college preparation is required of the applicant entering the school. Commencing with the class entering in 1934, however, candidates for admission to the freshman class will be required to present three years of college preparation of not less than 90 hours, completed in a college of satisfactory standing. A resolution adopted by the faculty during the past year provides that in considering applicants for admission preference should be given to those who are graduates of approved colleges and to those who have completed three years of college work and who signify that they will receive their academic degrees upon the satisfactory completion of the first year of the medical course. It was agreed, furthermore, that preference would be given to those applicants who had, in the opinion of the Committee on Admissions, evidence of high achievement in their college education and who are most likely to succeed in medicine, rather than to those who have limited their preparation to premedical sciences.

A number of important changes have taken place in the faculty of the college. The death of Dr. C. L. Bonifield, for many years professor of gynecology, removed from the faculty one of its oldest members and one who occupied a prominent place in the school and in the medical profession of Cincinnati.

The resignation of Dr. George E. Heuer as Holmes professor of surgery took effect at the close of the 1931-32 academic year. Dr. Heuer has become professor of surgery and head of the department of surgery at Cornell University Medical Center, New York City. Dr. Mont R. Reid, former associate professor of surgery, has been promoted to the position of Holmes professor of surgery and head of the department, succeeding Dr. Heuer.

Dr. C. A. Mills, who was on sabbatical leave during the last half of the 1931-32 session, has returned from studies in Europe. Dr. Albert P. Mathews, professor of biochemistry, is on leave of absence for the first semester of this school year.

Two additions to the faculty have been made. Dr. Glenn E. Cullen, formerly professor of chemistry, Vanderbilt University, has joined the staff of the department of pediatrics as professor of research pediatrics. He will teach in the graduate school and will be engaged in research under the Pediatric Research Foundation of the Cincinnati Children's Hospital. Dr. A. T. Childers has been appointed assistant professor of psychiatry. Other changes in the faculty are as follows:

Dr. John H. Foulger, promoted from assistant to associate professor of pharmacology. Dr. Frank M. Coppock, promoted from assistant to associate professor of gynecology. Dr. Louis A. Lurie, promoted from instructor to assistant professor of psychiatry. Dr. Samuel A. Brown, promoted from instructor to assistant professor of radiology. Drs. Ralph W. Staley, E. O. Swartz and Henry B. Freiberg, promoted from instructors to assistant professors of urology. Drs. John R. Stark and V. B. Roberts, promoted from instructors to assistant professors in gynecology.

During the past year, the new building housing the Out-Patient Dispensary, representing an expenditure of approximately $300,000, was completed and occupied. The dispensary activities which were formerly a function of the college were transferred to the Cincinnati General Hospital of which the dispensary now forms a department. The university is relieved of the cost of its operation but continues to be responsible for the medical service rendered.

Through the generosity of Mrs. Christian R. Holmes an ophthalmological unit has been established in the Christian R. Holmes Hospital, the private patient pavilion of the medical college.

Only minor changes were made in the curriculum for the present school year. However, a special Curriculum Committee is now engaged in a comprehensive study of the whole program of instruction and may recommend more extensive changes at a later date.

Officials of the college report that while the financial depression apparently has not seemed to affect the number of applicants for admission, it is apparent that some students are meeting with increasing difficulty in their efforts to remain in school, a problem which the university is endeavoring to help them solve.

The College of Medicine, University of Cincinnati, was organized in 1909 by the union of the Medical College of Ohio (founded in 1819) with the Miami Medical College of Ohio (founded in 1852). The Medical College of Ohio became the Medical Department of the University of Cincinnati in 1896. Under a similar agreement, March 2, 1909, the Miami Medical College also merged into the University when the title of Ohio-Miami Medical College of the University of Cincinnati was taken. The present title was assumed in 1915. The school has been coeducatonal since its

organization. The faculty consists of 95 professors and 155 associates, assistants, etc., a total of 250. The course covers four years of eight months each. A year's internship in an approved hospital is also required. The total fees for the four years are, respectively, $360, $360, $360 and $380, and if not a legal citizen of Cincinnati, $50 additional. Dr. Arthur C. Bachmeyer is dean of the college.

OHIO STATE UNIVERSITY, COLLEGE OF MEDICINE

The prevailing economic situation did not have an adverse effect on the enrollment in the College of Medicine, Ohio State University, as the 1932-33 school year opened, officials of the college report. In fact, rather the reverse was true, the total registration of 368 being the largest in the history of the school. The number of applications for admission to the freshman class was near the 1,000 mark which made the work of selecting the maximum number of 100 more difficult than usual. For a number of years, the college has restricted the freshman registration to 100, due to limitations of the physical plant and instructional staff.

Only resident students of Ohio are considered for admission. A large number of applications from without the state are received annually, but the policy of the college is that its first duty is to the citizens of Ohio and while so many native Ohioans are applying they should be given preference by the Entrance Board.

Enrollment statistics of the college for the years 1926 to 1932, inclusive, and the figures on graduation for the same period, show a distinct uniformity in the various classes and a mortality among students during the past few years of only 10 to 15 per cent, a fact which speaks well for the methods used in the selection of students applying for admission and the thoroughness of the instruction given:

NUMBER OF STUDENTS

	1932	1931	1930	1929	1928	1927	1926
Freshman	100	100	100	100	100	100	100
Sophomore	88	87	80	70	92	70	78
Junior	90	92	70	80	60	73	88
Senior	90	76	79	60	76	85	70
	368	355	329	310	328	328	336

GRADUATES

1932	1931	1930	1929	1928	1927	1926
75	77	58	74	82	58	77

Officials of the college point out that practically all of the 1932 graduates sought internships, which indicates the prevailing view of the value of this service and the place it has assumed as a definite part of medical education.

No additions to the physical plant have been undertaken and only minor changes made in the teaching staff.

However, the college has taken an important step in rounding out its new Department of Medical and Surgical Research by acquiring the services of Dr. George M. Curtis, formerly professor of surgery, University of Chicago, as professor of surgery and surgical research. The department, which began to function two years ago in charge of Dr. Charles A. Doan, formerly with the Rockefeller Institute, has become one of the principal divisions of the college. Dr. Doan is primarily engaged in medical research. Similar work in surgery will be undertaken by Dr. Curtis in addition to his regular duties as professor of surgery. Dr. Curtis is a graduate of the University of Michigan and Rush Medical College. He studied three years at the University of Berne, Switzerland, and has served at various time on the staff of the United States Public Health Service Hospital No. 30, Presbyterian Hospital and Billings Hospital, all of Chicago, in addition to extensive teaching experience at the University of Chicago, University of Michigan and Vanderbilt University.

The College of Medicine, Ohio State University, was organized in 1907 as the Starling-Ohio Medical College by the union of Starling Medical College (organized in 1847) with the Ohio Medical University (organized in 1890). In 1914 it became an integral part of the Ohio State University with its present title. It has been coeducatonal since its organization. The faculty consists of 48 professors and assistant professors, 76 lecturers, instructors, etc., a total of 124. Two years of collegiate work is required for admission. The course covers four years of thirty-four weeks each. Tuition fees are $196, $186, $186 and $196 each year, respectively, for residents of Ohio and are $150 additional for nonresidents. The dean of the College is Dr. J. H. J. Upham..

Vision Conservation

The numerous ways in which doctors, teachers, social workers, and others are striving to conserve the vision of American children are described in the annual report of the National Society for the Prevention of Blindness, made public by Lewis H. Carris, Managing Director. One of the specific instances of progress given is the further reduction of blindness from ophthalmia neonatorum. In 1931, only 7.5 per cent of all new admissions to schools for the blind had lost their sight from this cause, as compared to the 28 per cent disclosed by the records of 1907.

The society mentions the fact that industrial eye accidents are "probably the most serious cause of blindness." Most industrial eye accidents are preventable, the report says, but "it is estimated that in American industry more than 2,000 workmen lose one or both eyes, 300,000 minor eye injuries are received, and approximately $50,000,000 is wasted in time lost, compensation and medical bills, each year".

An Account Well Opened Is Half Collected So the Physician Should Secure Proper Credit Information and Know How to Interpret the Data Obtained

By W. H. Gray, Cleveland, Ohio

It is human nature to take the other fellow at his face value. It has long been a common fallacy to believe that we can correctly judge the other fellow without basing our conclusions on facts. It is not only in the professions but in every walk of life we find this strong, natural inclination to believe without investigation. Even at the Credit Bureau we have paid for that inclination.

There is a time for everything and it is particularly true in securing credit information. It is much easier in the beginning when the doctor is still viewed by the patient as an agent of mercy, than later, when the patient is cured and the only thing that looms in his mind is the doctor's bill.

The accompanying article by Mr. Gray, secretary-manager of the Cleveland Retail Credit Men's Company, is the second of a series being published in *The Journal* on business and legal questions of particular interest and importance to members of the medical profession and their secretaries. The papers reproduced in part in the series comprised a course in business administration presented by the Academy of Medicine of Cleveland in conjunction with the Cleveland Retail Credit Men's Company and are being published with their consent and through their courtesy. Because of space limitations in *The Journal*, it has been found necessary in some instances to abstract parts of the presentations made by the lecturers, but this has been done in such a way that the meaning, effect and much of the value of each have been retained.—*The Committee on Publication.*

It is surprising how much valuable credit information the doctor can secure directly from the patient by a general conversation as to employment, number of children, which ones at school, who his relatives are, etc. The patient will enjoy giving such information without ever becoming aware of what the doctor is actually doing. Generally it builds good will in the mind of the patient who entertains the idea that the doctor is most friendly and interested in him. Of course there are some doctors who have a practice which will not permit this. Information must then be secured by his secretary. It is my recommendation, however, that whenever possible the doctor should first interview the patient.

When the doctor has finished with the patient he should turn him over to his secretary, who can formally take his name in full, residence address, business, etc.

SECRETARY'S JOB

At this point the secretary's duty calls for the greatest amount of tact, diplomacy, and foresight, and makes her an invaluable asset to the doctor. She can prepare the way for prompt payment of the account and also build considerable good will for the doctor.

Bear in mind the axiom that an account well opened is half collected. Above all things, where possible, a very definite arrangement should be made with the patient as to payment for the services. I cannot emphasize too strongly the importance of a definite understanding as to payment. It is apparent that this arrangement can best be done by the secretary. Here she assumes the role of the doctor's business executive.

Your patients from morning until night are being high pressured by advertising and sales genuises to buy luxuries and what not. You can hardly expect Mary Brown to deny herself a fur coat, to pay a doctor who hasn't convinced her in the least that he expected to be paid promptly.

Should the patient immediately pay for the services, the secretary should still proceed to secure all the information she can without antagonizing him. In many cases where the patient pays for each call immediately, if the service extends over any period of time, credit will sooner or later be asked. Don't be afraid to ask for the information, as outlined above. Experience of thousands of professional credit grantors throughout the country show it to be a rare exception when people of honest intentions, object to telling about themselves.

If the payment is by check make notation for your records as to where the bank account is kept. This may be important later.

WATCH FOR THIS GAME

Do not give too much credence to the fact that the patient paid at time of making the first few calls. It isn't sufficient credit information, because a good many of the star dead beats, use that system for establishing credit. Often such a person plans in the very beginning to establish a friendly relation, in anticipation of later stinging the doctor.

In the first interview with the secretary it is well to have the patient give the name and address of a relative not of the immediate family. Such information is most helpful at a later date. Each year thousands of people move, forgetting to give the doctor their new address.

When the secretary has finished with the patient it is well for her and the doctor to compare notes as soon as convenient before the doctor forgets some of the points of information he elicited from the patient in his general conversation.

When the doctor makes a house call, he is given an opportunity to gather further information.

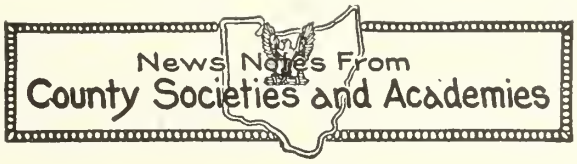
The mode of living, evidences of luxuries and waste not in keeping with the family's income, indifference in taking care of the home, etc., all of these items disclose traits of character.

We now come to the point of securing information from others, either references, social associates, employers, etc., and it becomes a problem as to what weight you should give such information.

Remember that in interpreting credit information, your judgment is never any better than the information you base your judgment on. So when you ask another about a person, find out if possible upon what they base their judgment. Often people given as reference will recommend the party for credit, but when asked if they would lend the party money, they start to change their story.

I haven't made mention of those emergency cases which apparently always stand out foremost in the doctor's mind in any discussion of credit matters. It is very true that in the emergency case it is not a question of credit information or being paid. But surely after the patient has been given the first treatment, or say two or three treatments, the doctor has had an opportunity to check into the case and ascertain which procedure he shall pursue with reference to the respective patient. If it is going to be a charity case why not consider it as such a case immediately? If the doctor expects to be paid why not immediately come to a definite understanding with the patient as to payment?

(Mr. Gray concluded his talk with a detailed description and explanation of how the cooperative credit bureau maintained by his company operates.)



First District

Adams County Medical Society held its regular monthly meeting on August 17 at the Courthouse at West Union. The program, starting at 10:30 a.m., was as follows: "Hemorrhagic Pancreatitis", Dr. F. C. Leeds, Winchester; "Preoperative and Postoperative Care of the Surgical Patient", Dr. W. G. Phillips, Maysville, Kentucky; "Gastroentertis", Dr. M. L. Purdin, West Union. A round-table discussion on case reports was held. Luncheon was served at the North Side Hotel—Bulletin.

Butler County Medical Society held an informal outing on August 24 at the White House Inn. A splendid dinner was served and the evening spent in social diversions.—News Clipping.

Clinton County Medical Society was entertained on September 6 at the camp of Dr. Frank A. Peelle, Port William Pike. Wives of the members were guests at the luncheon. The principal speaker was Dr. L. B. Johnston, Cincinnati, who talked on "Peptic Ulcer of Meckel's Diverticulum as a Cause of Internal Hemorrhage and Perforation".

The society held its August meeting on August 2 at the New Martin Hotel, Wilmington. The following case reports were presented: "Torsion of Ovarian Cyst", Dr. Kelley Hale; "Auto-Intoxication Due to Dental Caries", Dr. W. B. Yoakley; "Twins With One Still-Born", Dr. C. E. Kinzel; "Intrathoracic Tumor, Probably Accessory Thyroid; Fatal Termination", Dr. W. L. Regan; "Abdominal Aortic Aneurysm", Dr. C. A. Tribett. The program was closed by Dr. Robert Conard who presented a demonstration on "Physical Examination of the Lungs".—W. L. Regan, M.D., Secretary.

Highland County Medical Society met on August 10 at Leesburg, the guest of Dr. H. H. Lowe and Dr. K. R. Teachnor. About 20 members were present.—News Clipping.

Warren County Medical Society met in regular session September 6 at Harmon Hall, Lebanon. Dr. P. H. Kilbourne, Dayton, was the principal speaker. He read a paper on "The Eye".—News Clipping.

Second District

Darke County Medical Society resumed its fall sessions with a dinner meeting on September 9 at the Country Club. Wives of the members were guests. The principal speaker was Dr. J. H. J. Upham, dean of the College of Medicine, Ohio State University.—News Clipping.

Greene County Medical Society met on September 1 at the Courthouse at Xenia. Dr. Harold Ray, Cedarville, presented a paper on "Findings in the Physical Examinations of 700 Children at the Ohio Soldiers' and Sailors' Orphans' Home". The paper contained interesting pathological findings and brought out some valuable conclusions found from routine examination of children. The society adopted a resolution commending and complimenting the retiring president, Dr. R. H. Grube, for his valuable services.

The August meeting of the society was held on August 4 at which Dr. J. H. Dickinson, Day-

ton, read a paper on "Intestinal Infection in Children".—H. C. Schick, M.D., Secretary.

Miami County Medical Society was addressed by Dr. H. H. Wagner, Dayton, at its regular meeting September 2 at the Stouder Hospital, Troy. Dr. Wagner spoke on "Gynecological Conditions of Interest to General Medicine". A luncheon was served following the program—Bulletin.

Third District

Auglaize County Medical Society met August 11 at the St. Mary's City Hall, with Dr. O. E. Harvey, superintendent of the Lima District Tuberculosis Hospital as the principal speaker. The methods used in the operation of the institution and in the treatment of patients were described and explained by Dr. Harvey.—News Clipping.

Seneca County Medical Society held its annual outing on September 6 at Lake Mohawk. Dr. Louis J. Karnosh, Cleveland, was the principal speaker. Many physicians from surrounding counties attended, with their families. The afternoon was spent at cards and golf and following the dinner, Dr. Karnosh spoke.—News Clipping.

Fourth District

Putnam County Medical Society was addressed by Dr. W. W. Beauchamp, Lima, at its regular meeting September 1, at Columbus Grove. Dr. Beauchamp spoke on "What the General Practitioner Should Know About Endocrinology". A dinner at the Allen Restaurant preceded the meeting which was held at the Masonic Lodge rooms. —News Clipping.

Fifth District

Annual meeting of the *Fifth Councilor District* was held in the Allen Memorial Medical Library, Cleveland, on September 16, under the direction of Dr. Harry V. Paryzek, councilor of the Fifth District.

The morning program consisted of three papers: "Diagnosis of Pulmonary Tuberculosis", Dr. J. C. Placak; "Diagnostic Errors in Pulmonary Tuberculsis", Dr. Richard Dexter, and "Medical Management of Pulmonary Tuberculosis", Dr. R. C. McKay.

An organization luncheon was held at noon in the dining room of the Library under the auspices of the Anti-Tuberculosis League of Cleveland and Cuyahoga County.

In the afternoon, papers were presented by the following: Dr. S. O. Freedlander on "Surgical Treatment of Pulmonary Tuberculosis"; Dr. H. J. Gerstenberger and Dr. Herbert S. Reichle on "Tuberculosis in Infancy and Childhood"; Dr. V. C. Rowland on "Anemia of Pregnancy"; Dr. M. A. Blankenhorn on "Neurological Manifestations of Pernicious Anemia"; Dr. R. H. McDonald on "Treatment of Pernicious Anemia"; and Dr. R. D. Leas on "Treatment of Secondary Anemia".

Following a dinner in the evening, a combined meeting with the Cleveland Academy of Medicine was held. A brief address of welcome was made by Dr. Harry G. Sloan, president of the Academy. Dr. H. M. Platter, Columbus, president of the State Association, and Dr. C. L. Cummer, Cleveland, president-elect, addressed the gathering on organization problems. The program was concluded by an address by Dr. Gerald B. Webb, Colorado Springs, on "Practical Points in the Diagnosis and Therapy of Pulmonary Tuberculosis".

Dr. Paryzek was assisted in arranging for the splendid meeting and program by Dr. R. S. Dinsmore and H. Van Y. Caldwell, executive secretary of the Cleveland Academy of Medicine.

Medina County Medical Society was addressed by Dr. C. E. Jelm, Akron, at its regular meeting on August 11 at the Evanon, near Medina. Dr. Jelm spoke on "Management of Common Genito-Urinary Diseases". —Bulletin.

Sixth District

Portage County Medical Society held its annual outing August 10 at the home of Dr. and Mrs. R. D. Worden, Ravenna. Families of the members were guests. Outdoor sports were staged in the spacious grounds and in the evening cards and games were enjoyed. An elaborate dinner was served.

The first fall meeting of the society was held on September 1 at the Robinson Memorial Hospital, Ravenna. Dr. H. S. Davidson, Akron, councilor of the Sixth District, was the principal speaker, explaining the work of the Council of the State Association; analyzing some of the serious problems confronting the profession, and stressing close cooperation between the county societies and the State Association officers, committees and headquarters office. Informal talks were made by Dr. J. H. Selby and Dr. E. A. Weeks, of Akron, and Dr. Rebecca Evans, Denton, Texas, a guest at the meeting.—E. J. Widdecombe M.D., Secretary.

Stark County Medical Society met in regular session on September 13 at the Elks' Club, Canton. Dr. R. W. Scott, professor of clinical medicine, School of Medicine, Western Reserve University, was the principal speaker. He presented an essay on "Clinical and Pathological Observation on 2000 Autopsy Heart Cases". Lantern slides were used in the demonstration. The discussion on the paper was led by Dr. D. D. Shontz, Massillon.—Bulletin.

Summit County Medical Society met in regular session September 6 at the Mayflower Hotel, Akron. Dr. Harold N. Cole, associate clinical professor of dermatology and syphilogy, Western Reserve University, addressed the society on "The Management of Syphilis".

Wayne County Medical Society met August 9 at Wooster. The program consisted of a round-table discussion of a number of new and interesting medical questions.—News Clipping.

Seventh District

Columbiana County Medical Society held a golf-bridge outing August 25 at the Salem Golf Club. Many members of the dental profession were guests. No formal program was presented, the entire afternoon and evening being given over to fun and amusement.—Bulletin.

Eighth District

Fairfield County Medical Society held a social meeting August 18 at Summerland Beach, with the families of the members as guests Dinner was served at the Summerland Beach Hotel after which dancing and cards were enjoyed—News Clipping.

Guernsey County Medical Society was addressed by Dr. C. W. McGavran, Columbus, at its regular semi-monthly luncheon meeting at the Romance Restaurant, Cambridge, on September 1. Dr. McGavran spoke on "Esophageal Afflictions". The talk was highly illuminating to the members as were the lantern slides used to illustrate the address.

At its meeting on August 18, the society was addressed by Dr. Gordon Lawyer, Cambridge, on "Acute Prostatitis". Dr. Lawyer recently returned to Cambridge from six months' post-graduate work in urology in New York City. The talk was well reecived by the members.

Two veteran members of the society, Dr. B. A. Souders and Dr. W. G. Lane, were the principal speakers at the final July meeting of the society. Both made informal talks on their experiences during their long service in the profession.—O. Reed Jones, M.D., Correspondent

Muskingum County Medical Society held its first Fall meeting on September 7 at the Zane Hotel, Zanesville. The program was presented by Dr. Robert B. Drury, Columbus, who spoke on "General Surgery" and Dr. E. E. Campbell, Columbus, who read a paper on "Auricular Fibrillation".—News Clipping.

Perry County Medical Society met in regular session August 15 at the Park Hotel, New Lexington. Dr. G. G. Kineon, superintendent of the State Hospital for Epileptics, Gallipolis, was the principal speaker. He described the methods used at the institution in the care and treatment of patients. Dr. R. W. Miller, Hemlock, reported on a surgical case of "Hydronephrotic Kidney". The program was in charge of Dr. H. W. Shaw.—Bulletin.

Ninth District

Scioto County—The annual golfing tournament and outing of the Hempstead Academy of Medicine was held September 1 at the Raven Rock Country Club. Following a dinner in the evening at the Hurth Hotel, a five-reel film on "Cancer of the Skin" was shown. The outing was arranged by Dr. W. E. Gault and Dr. G. E. Neff.—Bulletin.

A Helpful Suggestion for County Society Programs

At a recent meeting of the Wayne County Medical Society, a considerable portion of the program was devoted to a discussion of questions asked by the Ohio State Medical Board at the June examinations given applicants for licenses to practice medicine and surgery in Ohio.

The report on the meeting stated that the feature "provoked a spirited discussion and was of such interest that it was decided to hold similar discussions frequently".

Here is a splendid suggestion for the program committees of other county societies.

In order to adequately test the medical graduate, the State Medical Board must recognize the new things which are being developed in the field of medicine and must quiz the applicant for a license on these new developments. This being the case, the examinations given twice a year by the board are good criterions of medical progress, and therefore are splendid tests also for the physician already in active practice.

Occasional "tests" of this sort at county society meetings should not only prove the medium for the exchange of ideas on fundamental medical questions but should also be an inspiration to each physician to keep up with medical literature, especially if he finds himself at a loss at times to give a coherent answer to some of the questions asked in the state examinations.

The examination questions asked by the State Medical Board are published regularly, following the examinations, in this *Journal*.

Post-graduate education does not always mean that the physician must spend several weeks or months each year in regular academic work or that he must attend elaborate programs of lectures and addresses. Much along this line can be done by the individual physician himself through the study of medical literature or by the county medical societies through programs similar to that given by the Wayne County Society. Round-table discussions provoked by the question-and-answer method often are more valuable than the formal and ultra-scientific address which may not touch on many of the practical problems which confront the physician in active practice.

The next written examination of the American Board of Obstetrics and Gynecology will be held on Saturday, October 22, at 2 p. m. in 19 different cities of the United States and Canada. Information on the examinations may be obtained from Dr. Paul Titus, secretary, 1015 Highland Building, Pittsburgh.

Deaths in Ohio

Lorin A. Beard, M.D., Pioneer; Michigan College of Medicine and Surgery, Detroit, 1890; aged 71; former member of the Ohio State Medical Association and the American Medical Association; died August 20 of heart disease. Dr. Beard had practiced in the vicinity of Pioneer for the past 42 years.

Andrew W. Bice, M.D., Spencerville; Kentucky School of Medicine, Louisville, 1896; aged 63; died August 9. Previous to locating near Spencerville, Dr. Bice had practiced for about 28 years in Lima. Surviving are three sisters.

William Stanley Bond, M.D., Hubbard; Starling Medical College, Columbus, 1890; aged 71; died August 9 as a result of a stroke of paralysis. Dr. Bond located in Hubbard soon after his graduation from medical school. He had served as county health commissioner and a member of the village council. Dr. Bond was a member of the Masonic Lodge, Kiwanis Club and the Methodist Episcopal Church. Surviving are one son, one sister and one brother.

William Allen Devaul, M.D., Kent; Starling Medical College, Columbus, 1890; aged 72; died August 12. Dr. Devaul began practice at Summerfield and later moved to Streetsboro. He had been located in Kent since 1926. Besides his widow, he leaves two sons, one daughter and two sisters.

Haldor L. Gahm, M.D., Jackson; Ohio State University, College of Medicine, 1912; aged 45; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died August 2 in Mt. Alto Veterans' Hospital, Washington, D.C. Dr. Gahm, the son of the late Dr. J. L. Gahm, had practiced in Jackson County until several years ago when he entered the government service and had been stationed at the hospital, where he died, for the past few years. He was a World War veteran, having held the rank of captain in the medical corps. Dr. Gahm was a member of the Masonic Lodge and the American Legion. He is survived by his mother, two brothers and one sister.

Charles S. Green, M.D., Fostoria; Western Reserve University, School of Medicine, 1886; aged 72; member of the Ohio State Medical Association and the American Medical Association; died August 24. Dr. Green was a native of Fostoria, and attended Ohio Wesleyan University before entering medical school. Dr. Green had practiced in Fostoria since his graduation. He was a member of the Masonic and Elks' lodges. His widow is the sole survivor.

Robert W. Hale, M.D., Fostoria; Beaumont Hospital Medical College, St. Louis, 1891; aged 65; died August 13 following a two years' illness. Dr. Hale, who had practiced at Fostoria for the past 41 years, had served as a member of the Fostoria Board of Health and was active in civic affairs. He leaves his widow, one son and one sister.

Wilmer Hammond, M.D., West Lafayette; Ohio Medical University, Columbus, 1905; aged 59; member of the Ohio State Medical Association and the American Medical Association; died August 31 of Bright's disease. Following his graduation from medical school, Dr. Hammond began practice in Otsego, the place of his birth and at the time of his death was coroner of Coshocton County. He was a member of the Masonic Lodge and the Methodist Episcopal Church. Surviving are his widow, one daughter, three sisters and five brothers.

Lemuel E. Hecker, M.D., West Liberty; Cincinnati College of Medicine and Surgery, 1885; aged 77; died September 1. After graduating from medical school, Dr. Hecker practiced for a time in Lafayette, Indiana. In 1888 he moved to Dayton where he practiced until 1909 when he moved to Toledo. Dr. Hecker retired from active practice in 1930, moving to his farm near West Liberty. He leaves his widow and one grandson.

Carl O. ImOberstag, M.D., Toledo; Toledo Medical College, 1902; aged 55; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died August 10 of pneumonia. Dr. ImOberstag was a Mason and a member of the Evangelical Lutheran Church. Surviving are his widow, two sons, three brothers and three sisters.

Frank L. Newburg, M.D., Toledo; Toledo Medical College, 1903; aged 68; member of the Ohio State Medical Association and the American Medical Association; died August 13 at the Marine Hospital, Cleveland. He was a World War veteran. He leaves his widow and two brothers.

William O. Osborn, M.D., Cleveland; Cleveland Medical College, Homeopathic, 1895 and School of Medicine, Western Reserve University, 1898; aged 65; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died September 3 following a brief illness. He had practiced in Cleveland for 34 years. During the war, he was a member of the Federal Medical Advisory Board. Surviving are his widow, two sons and two daughters.

Willis F. Persons, M.D., Magadore; Western Reserve University, School of Medicine, 1884; aged 75; died August 24 following a stroke of paralysis. Dr. Persons had practiced in Sullivan

for the past 30 years, retiring only a few months ago because of ill health. He was a member of the Masonic Lodge. Surviving are four sons and three daughters.

Aurelius E. Smith, M.D., Utica; Starling Medical College, Columbus, 1883; aged 75; died August 19 at the home of his son in Columbus following an extended illness. Dr. Smith has practiced at Utica, for the past 40 years, being forced to retire three years ago because of his health. Besides his one son, he leaves one brother and one sister.

Eli H. Westfall, M.D., Beloit; Western Reserve University, School of Medicine, 1889; aged 70; died August 17 following a heart attack while playing golf at the Sebring Country Club. He had practiced medicine in Beloit since 1897. Surviving are one brother and one sister.

KNOWN IN OHIO

John J. Conzett, M.D., Auburn, N. Y.; Miami Medical College, Cincinnati, 1899; aged 59; died August 9. Dr. Conzett was formerly connected with the Cincinnati Board of Health and had resided in Cincinnati for many years. He was a Spanish-American and World War veteran. Surviving are his widow and four sisters.

John G. Gehring, M.D., Bethel, Me.; Western Reserve University, School of Medicine, 1885; aged 75; Fellow of the American Medical Association; died September 1. He was a native of Cleveland and practiced there for a number of years before going East.

Edward D. Harper, M.D., Indianapolis; Columbus Medical College, 1889; aged 66; died August 26 of angina pectoris at the home of his daughter, Mrs. Harry Hulbert, Athens County. Dr. Harper, a former resident of Guysville, was visiting his daughter at the time of his death. Following the World War, in which he served, Dr. Harper moved to Indianapolis. He is survived by two sons and one daughter.

Edward A. North, M.D., Newport, Ky.; Eclectic Medical College, Cincinnati, 1906; aged 51; Fellow of the American Medical Association; died August 8 at the Fort Hamilton Hospital, Hamilton, of heart trouble. He leaves his widow, one son, two brothers and two sisters.

Fourth Annual Post-Graduate Course of the Lima and Allen County Academy of Medicine was held on September 26 to 30, inclusive at Lima. The lectures were delivered by Dr. Julius Bauer, professor of medicine, University of Vienna, Austria, on the following subjects: Constitutional Factors in Disease, Arterial Hypertension, Hyperthroidism, Obesity, So-called Rheumatism, Parenchymatous Lesions of the Liver, Diseases of the Pituitary Gland and Suprarenal Syndromes.

Program for Northwestern Ohio Meeting, October 4, at Lima

Arrangements have been completed for the Eighty-eighth Meeting of the Northwestern Ohio Medical Association, to be held at the Elks' Club, Lima, on Tuesday, October 4.

On Monday, October 3, the annual golf tournament of the association will be played at the Shawnee Country Club, starting at 1 p.m. A banquet for the golfers will be held in the evening. Arrangements for the tournament have been made by Dr. E. H. Hedges, Dr. O. S. Steiner and Dr. H. F. Webb.

The following program will be presented at the Tuesday meeting.

9:30 a.m. to 12:15 p.m.—

Business Session.

"Toxaemias of Pregnancy," Dr. W. J. Dieckman, Chicago.

"The Chronic Sinus in Its Relation to Asthma and Bronchitis—Its Proper Management," Dr. Ferris Smith, Grand Rapids, Michigan.

"Some Clinical Applications of Electrocardiography", Dr. Edward D. Spalding, Detroit.

12:15 p. m. to 1:30 p.m.—

Luncheon.

1:30 p.m. to 4:30 p.m.—

"The Treatment of Carcinoma of the Colon and Rectum", Dr. Richard B. Cattell, Boston.

"The Roentgenologic Manifestations and Differential Diagnosis of Neoplasms of the Large Intestines", Dr. Harry Weber, Rochester, Minn.

"The Application of the Principles of Nutrition to Daily Practice", Dr. A. Graeme Mitchell, Cincinnati.

"The Treatment of Prostatic Obstruction with the Electro-Resectoscope", Dr. Herman L. Kretschmer, Chicago.

6:30 p.m.—

Dinner at Argonne Hotel.

"The Medical and Surgical Treatment of Gastric and Duodenal Ulcers", Dr. Frank Lahey, Boston.

Officers of the association who had charge of arranging the meeting are: President, Dr. V. H. Hay, Lima; first vice president, Dr. E. H. Porter, Tiffin; second vice president, Dr. C. M. Harrison, Napoleon; treasurer, Dr. E. L. Brady, Marion, and secretary, Dr. C. E. Hufford, Toledo.

Dr. Percy L. Harris, Cleveland, graduate of the Rochester School of Medicine and Surgery, has been granted through reciprocity a license to practice medicine and surgery in Ohio.

Twenty-second Annual Clinical Congress of the American College of Surgeons will be held in St. Louis, October 17 to 21, with headquarters at the Jefferson Hotel.

NEWS NOTES of OHIO

Youngstown—Annual golf outing of the Mahoning County Medical Society was held at the Squaw Creek Country Club, ending with a fine chicken dinner and a social time. Honors in the golf tourney went to Dr. Joseph Nagel, low gross; Dr. Samuel Tamarkin, blind bogey; Dr. James Brown, low net; Dr. Samuel Sedwitz, most par holes; Dr. Wendell Bennett, best poker hand, and Dr. Robert Morrison, best dressed player.

Cleveland—Low scores featured the annual golf tournament of the Cleveland Academy of Medicine at the Westwood Country Club. The first leg on the new Prendergast Cup for low gross was won by Dr. J. J. Marek, with an even 80. Dr. E. P. McNamee and Dr. R. P. Bell tied for second low gross with 81's. Other prize winners were: Drs. R. S. McGinnis, W. E. Dwyer, F. C. Oldenburg, E. A. Peterson, W. H. Phillips, E. D. Saunders, L. J. Carson and M. R. Kellum.

Cleveland—Dr. R. P. Estes is recovering from injuries sustained when he was caught between a street car and a safety zone standard.

Cleveland—Dr. W. C. Gill is convalescing from an attack of appendicitis.

Canton—Dr. E. O. Peterson has been appointed by the Council on Medical Education and Hospitals of the American Medical Association as advisor to the council in the matter of passing on and listing qualified radiologists from the northeastern section of Ohio.

Cincinnati—Dr. J. Edward Pirrung has returned from a three months' European travel tour of various continental clinics.

Macon—Dr. Russell M. Brewer, who recently completed his internship, has established offices for private practice here.

North Hampton—Offices for general practice have been opened here by Dr. Robert Taylor, a graduate of the School of Medicine, Western Reserve University.

Celina—Dr. D. H. Richardson, veteran local physician, recently celebrated his 84th birthday. Many of his friends paid him an informal visit to congratulate him.

Elyria—Dr. H. F. Gammons spoke on "Modern Ideas of the Diagnosis and Treatment of Tuberculosis" at a recent meeting of the Elyria Kiwanis Club.

Akron—Dr. L. E. Wharton, Dr. W. R. Rechsteiner and Dr. M. F. Bossart have returned from a Canadian fishing trip.

Novelty—A portrait of Dr. Frederick G. Banting, discoverer of insulin, was unveiled recently at No Mita Koda Camp for diabetic children near here. More than 300 attended the ceremonies. Speakers were Dr. Henry J. John, founder of the camp; Dr. Harry G. Sloan, president of the Cleveland Academy of Medicine, and Dr. Lewellys F. Barker, professor emeritus of medicine, Johns Hopkins University.

Sebring—Dr. L. C. Couchman, who recently completed his internship at the Youngstown City Hospital, has opened offices here.

Waynesville—Dr. Edwin F. Deppe, former intern at the Miami Valley Hospital, Dayton, has located here.

Stone Creek—Dr. H. H. Schwindt, graduate of the College of Medicine, Ohio State University, has opened offices here.

Lexington—Dr. Milton C. Oakes, formerly on the staff at Children's Hospital, Columbus, has opened an office for general practice here.

Minister—Dr. Paul C. Bratten has opened offices here. He formerly was an intern at the Miami Valley Hospital, Dayton.

Toledo—Dr. Rees Klopfenstein, formerly instructor of surgery at the University of Michigan, has located in Toledo.

Celina—Offices have been established here by Dr. Robert Beare, formerly an intern at the Good Samaritan Hospital, Cincinnati.

Dublin—Dr. Henry W. Karrer, graduate of the College of Medicine, Ohio State University, is conducting private practice here.

Washington, C. H.—Dr. James M. Harsha has been appointed resident physician for the Baltimore & Ohio Railroad.

Wooster—Dr. Guy H. Williams, superintendent of the Cleveland State Hospital, spoke at a recent meeting of the Wooster Kiwanis Club.

Elyria—Dr. W. E. Wheatley has been elected a trustee of the Lorain County Tuberculosis Sanatorium.

Cincinnati—Erection of a $43,000 addition to Hanna Hall on the University of Cincinnati campus has been started. It will house the new Science Research Laboratory.

Middletown—Dr. E. M. Morris has returned from Rochester, N. Y., where he took postgraduate work at the University of Rochester.

Mansfield—Local physicians defeated Mansfield lawyers, 35 to 10, in a golf match played at the Westbrook Country Club. Dr. P. A. Stoodt was low scorer with a gross card of 87.

Zanesville—Dr. and Mrs. W. L. Cruise have sailed for Europe where Dr. Cruise will take post-graduate work at Vienna and Budapest.

Martins Ferry—Announcement has been made of the marriage of Miss Mary E. Michael and Dr. Richard H. Wilson.

Toledo—Dr. J. I. Gould, for the past two years resident physician at the Robinhood Hospital, has opened an office for private practice.

Lodi—Dr. J. G. Whitacre and his wife, Dr. Clarice E. Whitacre, and their daughter, Ruth, are on an extended tour of Europe. The Drs. Whitacre will take post-graduate work at the University of Berlin before returning to this country.

Middletown—Dr. H. O. Lund was injured in an automobile accident near South Excello.

Canton—Dr. L. H. Werley has been appointed city physician.

Akron—Dr. E. V. Thiehoff has resigned as chief of the child hygiene service of the local health department and has moved to Cleveland.

Dayton—Dr. Vernon L. Hart, former assistant professor and surgeon in charge of the bone and joint division of the Department of Surgery, University of Michigan, has assumed his new duties as chief of the orthopedic service of the Dayton Clinic.

Akron—Dr. H. L. Smallman has been taking post-graduate work in surgery at New York City and Drs. A. S. McCormick and O. P. Allen post-graduate work in anesthesia in Cleveland and Toledo, respectively.

Circleville—Dr. and Mrs. Howard Jones recently celebrated their 50th wedding anniversary.

Akron—Dr. G. A. Ferguson has qualified at the Akron airport as a pilot.

Lancaster—Dr. C. A. Barrow has been appointed by the city council to care for the indigent of the city.

Cincinnati—Among the works of art on display at the annual exhibition for American physicians, sponsored by the New York Academy of Medicine at the academy building, New York City, is a painting by Dr. Martin Fischer, Cincinnati.

Sandusky—Dr. J. L. Carroll has been employed by the city commission as city physician.

Mansfield—Dr. F. W. Gillig, graduate of the Loyola University Medical School has opened offices for general practice here.

Ironton—Dr. V. B. Wood, who for the past year has been associated with his uncle, Dr. Cosper Burton, in the practice of medicine, has opened offices of his own at Fifth and Washington Sts.

Middletown—Dr. E. T. Storer was a speaker at the recent meeting of the local Business and Professional Women's Club.

Middleport—Dr. E. F. Maag, formerly of Columbus, has re-opened offices here.

Columbus—Dr. John W. Larcomb has been named a city physician under the city health department.

Youngstown—Dr. W. C. Redd has been named assistant to Dr. N. J. Nardacci, city physician.

Dover—Announcement has been made of the marriage of Dr. Edgar C. Davis, this city, and Miss Cordelia R. Hoffman, Baltic, formerly a nurse at the Union Hospital.

Bucyrus—Dr. Clarence Schoolfield, son of Dr. and Mrs. E. R. Schoolfield, has established an office for general practice at Carbon, West Virginia.

Van Wert—Dr. and Mrs. A. T. Rank were seriously injured in an automobile accident near Griffon, Georgia, according to word received by Van Wert relatives.

Conneaut—Announcement has been made of the marriage of Miss Marion Olmsted and Dr. Clarence T. Risley, both of this city.

Greenwich—Dr. C. B. Thomas, recently of St. Luke's Hospital, Cleveland, has located here.

Oberlin—Offices have been opened here by Dr. G. Y. Swickard, formerly of Toledo.

Barnesville—Having completed his internship at Grant Hospital, Columbus, Dr. Paul Modie has opened offices here.

Ottawa—Dr. Wilbur Light has become an associate of his father, Dr. Frank Light. He recently completed his internship in the Indiana University Hospital.

Elyria—Offices for general practice have been opened here by Dr. M. R. Martin, formerly resident physician at the Elyria Memorial Hosiptal.

Cadiz—Harrison County commissioners have appointed Dr. L. B. Parks physician for the county home and Dr. A. B. Tubbs physician for the county jail.

Sidney—Dr. M. F. Hussey has been appointed by the county commissioners physician for the county home.

Toledo—Dr. J. H. Smith has been appointed a medical examiner for the aeronautics division of the U. S. Department of Commerce.

Bellaire—An interesting discussion on the *X*-ray, illustrated with lantern slides, was presented at a recent meeting of the Bellaire Kiwanis Club by Dr. L. D. Covert.

HOSPITAL NOTES

—Miss Winifred Sink has been appointed educational director of the Mansfield General Hospital. She formerly resided at Ft. Wayne, Indiana.

—Cornerstone of the new Lima Memorial Hospital was laid recently at appropriate ceremonies at which Colonel Ralph D. Cole, new commander of the American Legion of Ohio, delivered the principal address.

—Dr. Edward L. Voke has assumed his duties as head of the radiology department of People's Hospital, Akron. He formerly was connected with the *X*-ray department of Memorial Hospital, New York City.

—A surprise party was given A. E. Hardgrove, superintendent of the Akron City Hospital, on September 1, the tenth anniversary of his taking over the management of the institution. Members of the staff, the trustees and the interns of the hospital acted as hosts.

—The nurses' school of the Home and Hospital, Findlay, has been closed due to a shortage of operating funds.

—The Children's Hospital, Columbus, will receive $1000 under the will of the late Mrs. Chauncey Baker, recently probated.

—Drs. Howard Maxwell and O. G. Thompson have been appointed associate members of the staff of the Alliance City Hospital.

—Edward S. Babcox, president of the board of trustees of People's Hospital, Akron, has announced the gift of $13,000 worth of radium by an anonymous donor.

—The nurses' training school at the Lake County Memorial Hospital, Painesville, has been closed indefinitely because of lack of funds.

—Miss Ada Leonard, formerly principal of nursing, has been named acting superintendent of the Middletown Hospital, succeeding Miss Mabel E. Pittman, resigned.

—The Huron Road Hospital (Cleveland) building committee has petitioned the Reconstruction Finance Corporation for funds with which to finish the new building, now about two-thirds completed. Approximately $600,000 has been spent on the proposed $952,000 structure, no funds now available for completion of the building.

—The 80th anniversary of the founding of Charity Hospital, Cleveland's first hospital, was celebrated recently with a mass conducted at the institution. More elaborate ceremonies are being planned for October 10 at which Bishop Joseph Schrembs, now in Europe, will preside.

—Mansfield General Hospital was bequeathed $2,500 under the will of the late Mary P. Weldon, recently probated.

—R. A. Bates, formerly of Davenport, Iowa, has assumed his duties as superintendent of the Piqua Memorial Hospital.

—Good Samaritan Hospital, Sandusky, will receive $5,000 under the will of the late Russell K. Ramsey, attorney.

—At a recent meeting of the staff of St. Joseph's Hospital, Warren, the following officers were elected: President, Dr. D. G. Simpson; vice president, Dr. A. E. Smith; secretary, Dr. S. J. Shapiro; councilors, Dr. J. J. Bellas and Dr. P. N. Mutschmann.

—Dr. E. C. Fischbein and Dr. James Sagebiel have been named medical directors of the Orchard Springs Sanitorium, Dayton, succeeding Dr. Charles B. Rogers, resigned.

—The following officers have been re-elected by the medical staff of the Newark City Hospital; chief of staff, Dr. E. A. Moore; assistant chief of staff, Dr. J. W. Barker; secretary-treasurer, Dr. W. H. Morgan; directors, Dr. Carl Evans and Dr. H. J. Davis.

—Dr. R. W. Croyle has resigned as assistant superintendent of the Massillon State Hospital, to enter private practice in Massillon. He will be succeeded by Dr. C. D. Rian, a member of the medical staff, and Dr. Rian's place on the staff will be filed with Dr. William W. Corwin, Rushsylvania.

—Dr. Frank L. Lacksen, formerly of Hamot Hospital, Erie, Pa., and a graduate of Ohio State University, has joined the staff of Wells Hospital, Cambridge.

—The new Bucyrus Municipal Hospital, said to be one of the finest medium-sized institutions in Ohio, was officially dedicated Sunday, July 10.

—Dr. Hobart L. Donohoe has assumed his new duties as resident surgeon at Children's Hospital, Columbus.

The following physicians have been granted licenses through reciprocity by the State Medical Board to practice medicine and surgery in Ohio: Frank K. Harder, Cincinnati, Harvard Medical College; Gerald J. Krupp, Lorain, St. Louis University; Water L. McCaleb, Beaver, Vanderbilt University; Frank S. Orland, Akron, Temple University; George R. Wiseman, Jr., Amherst, Detroit College of Medicine and Surgery, and John F. Dulick, Petersburg, St. Louis University.

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PUBLIC HEALTH NOTES

—A resolution endorsing a move to combine the Green County and Xenia health districts has been adopted by the Greene County Medical Society. Newspaper accounts stated that the proposed merger had its inception when it became known that Dr. R. H Grube, Xenia, for the past 12 years health commissioner of Greene County, is intending to retire in the near future.

—City council of Sidney has approved a joint arrangement of the city and Shelby County boards of health for combining the county and city into one general health district and authorized the mayor to enter into a contract with the combined district for public health services for the city.

—An effort is being made to have the voters of Zanesville pass at the November election on a resolution requesting the county commissioners to establish a tuberculosis sanitarium in Muskingum County.

—Annual conference of the Northwestern District, Ohio Federation of Official Health Workers, was held August 4 at Put-in-Bay. Dr. H. J. Powell, health commissioner of Bowling Green and Wood County, presided in the absence of Dr. Roy C. Hunter, health commissioner of Auglaize County and chairman of the district organization. Those who spoke were Dr. H. G. Southard, state director of health; Dr. F. M. Houghtaling, health commissioner of Sandusky and Erie County, president of the state federation, and Paul Mason, publicity director of the State Department of Health. Arrangements for the meeting were made by Dr. C. B. Finefrock, health commissioner of Ottawa County.

—A treatise on "Influenza" has been written by Dr. Finley Van Orsdall, chief of the Division of Communicable Diseases, State Department of Health, and is available in booklet form at the offices of the State Department. It traces the history of influenza from the period 412 B.C., presents statistics on the prevalence of the disease in Ohio for the past 11 years, including mortality figures, and outlines the scientific phases of prevention, diagnosis and treatment of the disease.

—One of the feature attractions at the State Fair, held in Columbus the last week in August, was the exhibition staged by the State Department of Health. Practically every division of the department presented exhibits and numerous activities of the department were described by exhibits, talks, graphs, etc.

—Dr. E. S. Godfrey, director of local health administration, New York State Department of Health, has completed a tour of many Ohio counties, studying methods used in this state to furnish health service through county and city health departments. He was obtaining material to be used in formulating plans for expansion of local health work in New York state.

—Summer meeting of the Northeastern District, Ohio Federation of Official Health Workers, was held August 10 at the Massillon State Hospital. About 100 attended the conference. Following a business meeting in the morning, a luncheon was given, after which Dr. Arthur G. Hyde, superintendent of the hospital, addressed the gathering. His talk on mental hygiene problems was followed by a clinical demonstration of the various psychoses.

The meeting was presided over by Dr. Frank M. Sayre, health commissioner of Canton. The State Department of Health was represented at the conference by Dr. H. G. Southard, state director of health; Dr. E. R. Shaffer, chief of the division of local health organization, and Dr. R. W. DeCrow, chief of the bureau of venereal diseases. At the business session, the following officers were elected: Chairman, Dr. M. D. Ailes, health commissioner of Akron; Vice Chairman, Dr. T. T. Church, health commissioner of Salem and Columbiana County; Secretary, Miss Elizabeth Yost, R. N., Akron.

—Dr. J. B. Poling, city health commissioner of Lima, entertained members of the board of health, city officials and a few other guests at dinner at his home recently.

—Dr. H. S. Allen has been reappointed health commissioner of the city of Ironton.

—Dr. G. N. Anderson of Fayetteville, has been appointed health commissioner of Brown County, succeeding Dr. W. L. Faul, Russellville.

—Under the direction of Dr. M. D. Ailes, city health commissioner, a plan has been drawn up by the health department for the mobilization of approximately 200 experienced persons in case of a major catastrophe in Akron, which might menace the health of the public.

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Attorney General Rules on Public Employes, Poor Relief and Workmen's Compensation When Inter-related

In a recent opinion to the State Industrial Commission, Attorney General Gilbert Bettman clarified a number of statutes of the General Code on the furnishing of poor relief with reference to whether or not persons performing labor, as provided for in those statutes, would if injured, be entitled to benefits of the Workmen's Compensation Act.

Section 3476, General Code, specifies what political sub-divisions shall furnish poor relief; to whom it shall be rendered, and how.

Section 3493, General Code, provides that when public relief, not in a county or city infirmary, is applied for and the applicant is able to do manual labor, the officers of the sub-division giving the relief shall require him to perform labor to the value of the relief afforded upon the public highway or in any public park or on any public property.

Analyzing the provisions in relation to the Workmen's Compensation Law, Attorney General Bettman ruled:

1. When a person, who applies for relief as provided for in Section 3476 et seq. of the General Code and in pursuance thereto performs labor as provided for in Section 3493, General Code, is injured while performing such labor, he is not an employe within the meaning of the Workmen's Compensation Law of the State of Ohio and is not entitled to the benefits of the act.

2. When such person in performing labor under Section 3493, General Code, works on a project which is being financed by the gasoline tax moneys and enters into an agreement with the city that his name be placed upon the payroll and the amount which he would receive as wages, if he were being paid wages which in fact he is not, may be turned over to the city and placed in the general revenue fund, his status is not changed. Such transfer of funds is unauthorized and illegal. Such person is not an employe within the meaning of the Workmen's Compensation Law.

3. A person who applies to a private charitable organization for relief and is required by that organization to perform labor for some other person or for some political sub-division, free of charge, before relief is given, is not working under a contract of hire nor engaged in the business of organization; and if such applicant is injured while performing such work, he is not to be considered an employe within the meaning of the Workmen's Compensation Law and is not entitled to the benefits of the act.

4. Where a person applies to a private charitable organization or public officer for relief, and before he can obtain such relief is required to perform services for the public sub-division, and in the performance of such services the officers of the subdivision agree to pay him for the services which he renders at least a part of that which he is to receive, such person is an employe of the political sub-division within the meaning of the Workmen's Compensation Act, and in case he is injured he is entitled to the benefits of the act.

5. When an applicant presents himself to the department of charities for relief under the poor laws of the State of Ohio, and such department refers him to some public officer who hires him to perform public work for a valuable consideration, which consideration is paid from the funds of the department of charities, such applicant is an employe within the meaning of the Workmen's Compensation Law, and in case he is injured would be entitled to the benefits of that act.

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The Radiologists of Cincinnati have organized a society which is to be known as the Radiological Section of the Cincinnati Academy of Medicine. It is to be a unit of the Academy although it operates under its own constitution and has its own officers. For the ensuing year the president is to be Dr. Sidney Lange and the secretary-treasurer is Dr. H. G. Reineke.

Newton Falls—Dr. Robert J. Emslie, formerly of Cleveland, has opened offices here.

Lorain—Medical problems were discussed by Dr. Leonard Stack at a recent meeting of the Lorain Hi-Y Club.

Cleveland—Dr. J. J. Randall has resigned as superintendent of the Sunny Acres tuberculosis sanatorium at Warrensville. He will take a similar post at Troy, N. Y.

Bloomdale—Dr. Ralph E. Rasor, who recently completed his internship at the Harper Hospital, Detroit, has located here.

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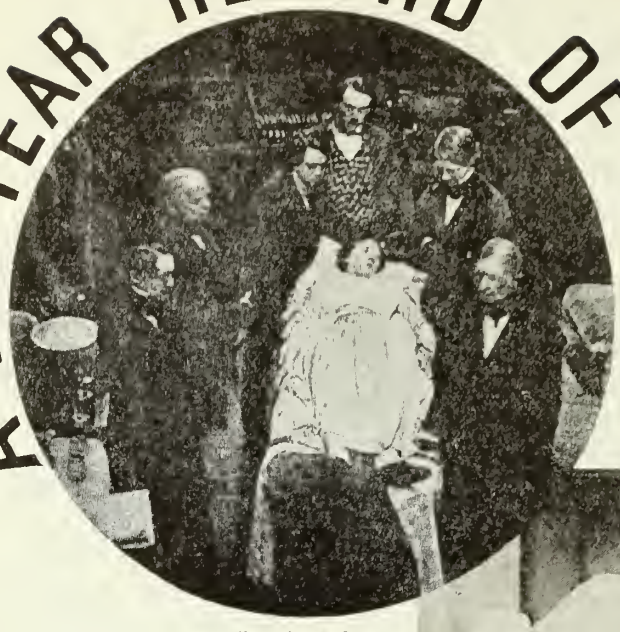
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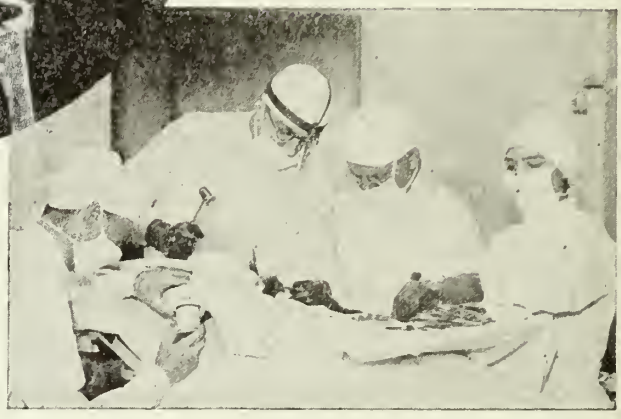
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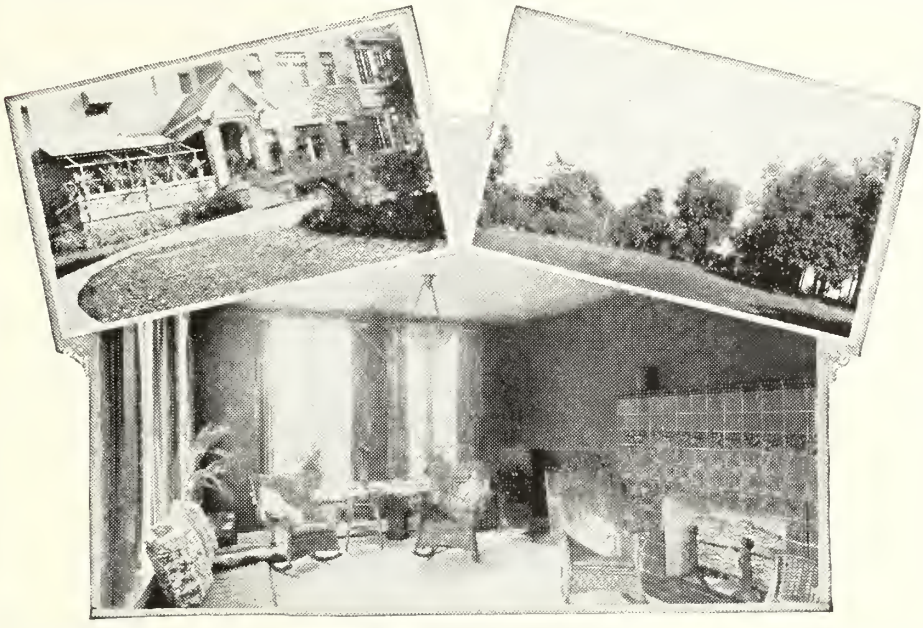
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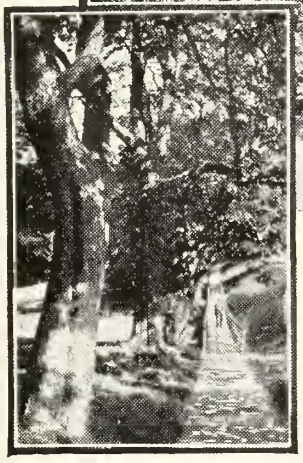
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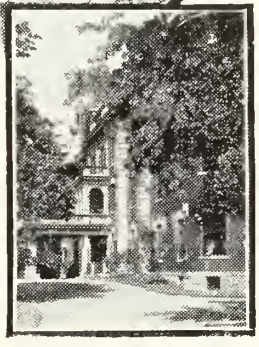
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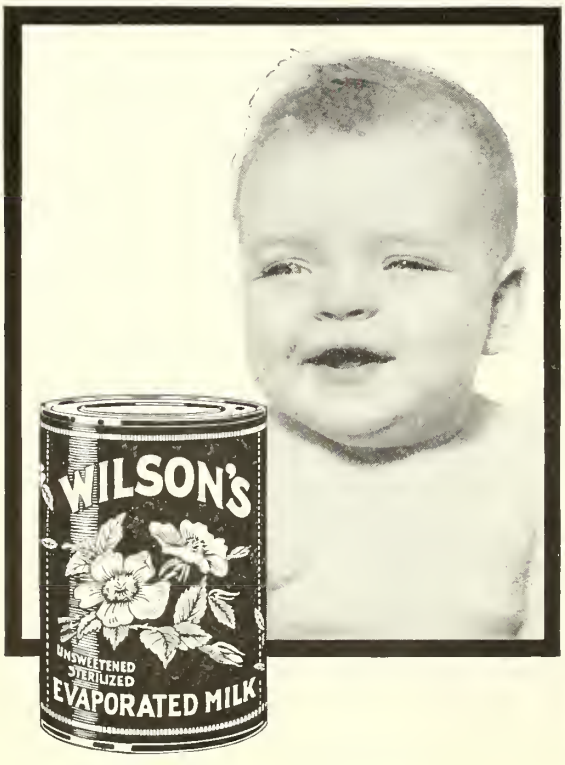
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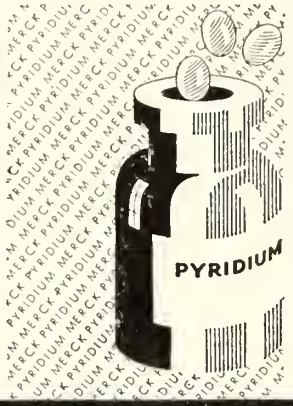
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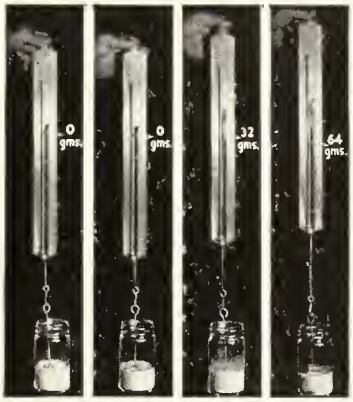
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[1] Morse and Talbott, Diseases of Nutrition and Infant Feeding, pgs. 214, 215.

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PUBLIC HEALTH - SOCIAL WELFARE MEDICAL ECONOMICS and ORGANIZATION PROBLEMS

With Editorial Comment by D.K.M.

Essentials In Organization

Organization activities by the county medical societies and academies of medicine of Ohio during the busy fall and winter months offers an opportunity for self-analysis on the part of medical organization as to its present state of preparedness to meet pending, as well as potential, problems of vital importance to the medical profession, individually and collectively.

Recent social and economic developments, and definite movements on the part of a few individuals and groups to bring about radical changes in methods of supplying the public with medical care have had an awakening effect on the medical profession generally.

There already has been marked change during the past few years in the social and economic aspects of the practice of medicine.

Important and fundamental questions, with far-reaching implications from the standpoint of the practice of medicine, which in the past might have been ignored or underestimated by members of the profession, have been thoroughly and widely discussed in medical circles. For this reason, no physician who has shown even a slight desire to keep in touch with medical-social developments is at the present time wholly unfamiliar with some of the important questions about which the entire profession should be deeply concerned.

The time has come when the medical profession and medical organization need no longer ask the question: "What are the problems which confront us?", but must concentrate on finding an answer to the query: "Are we prepared to meet the present day issues and those which we know we will be called upon to face?".

Strong and active organization is one of the fundamental factors in preparedness. Effective organization is based on interest, esprit de corps, and sufficient machinery to carry on the activities necessary for ultimate success.

Organization machinery was established by the medical profession in Ohio some eighty odd years ago. The medical pioneers of the state were quick to realize that the interests of the public as well as the profession would be better served through the federation of the profession into one compact organization than through the unorganized efforts of individual physicians.

Few changes in the mechanical set-up of medical organization in Ohio have been made during this long period. Few have been needed. Made up as it is of the various county medical societies and academies of medicine and established on a democratic and representative basis, the State Association has functioned effectively and faithfully in promoting the purposes for which it was founded.

What is the situation today?

The machinery which has been operated efficiently and effectively in the past is still intact. Leadership of the highest caliber has been provided. The influence and the prestige of the State Association have been established.

Whether medical organization in Ohio will be able to meet its responsibilities and duplicate its successes of the past in safeguarding scientific medicine, preserving the present standards of medical practice, and promoting the best interests of the individual physician depends largely on the other factors in successful organization, namely: (1) The active, united and enthusiastic interest of every member in the activities and program of medical organization, and, (2) the enlistment of every eligible physician in the state in the cause of organized medicine.

It is imperative at present that every county medical society impress its members with the necessity for strong medical organization. Wholehearted cooperation in the activities of local, state and national units of medical organization should be urged. Every eligible physician in every county should be shown the benefits which he would derive through membership in his county medical society and the State Association. Likewise, every physician should be impressed with the obligation he owes himself and his profession in giving his active support to the organized efforts of the medical profession.

As pointed out by one medical writer:

"We must deal collectively with the exploitation of medicine. The safety of the public in matters of life and health rests upon the initiative of our profession. The preservation of all that is best in the traditions of our profesison, of all that has been produced in the development of the science of medicine can be accomplished only in a closed union of our individual interests."

It must not be forgotten that medical organi-

zation has been, and will continue to be, the most powerful influence in the protection and maintenance of the personal interests of the individual physician. The fact should not be lost sight of that medical organization has consistenly demanded that the economic security of the individual practitioner be insured along with the welfare of the public at large in any new form of medical practice which may be evolved. Medical organization has not overlooked the fact that the personal, human element in medicine predominates.

A pertinent point on this phase of medicine was made by a speaker at the recent Secretaries Conference of the Illinois State Medical Association when he said:

"After all, medical practice is secondary to, and dependent upon, the progress of the medical profession. Solution of the problems of the profession is the means to an end. Let the profession fail and medical practice fails also. Medical practice does not stand alone and for that reason cannot endure unmolested without the protection of the medical profession. Medical practice is merely a child of the medical profession and without proper organization becomes an orphan."

Through the maintenance of strong medical organization, the medical profession will have reasonable assurance that its economic security will be protected and safeguarded, and therefore that it will be permitted to keep pace with the advancement of scientific medicine. Under such conditions, sound medical practice can be carried on and competent medical care provided.

Much depends on how the medical profession acts to meet the present crisis. Only by united action can it hope to weather the storm and preserve those proven principles which it knows to be best for the public and for its own members.

Political Participation by Physicians

Recently, a number of organizations of statewide scope and with memberships consisting of individuals engaged in varied business and professional undertakings have held their annual meetings in various sections of the state.

Those informed concerning the proceedings at the gatherings of a number of the larger and more influential organizations have expressed surprise at the interest displayed in the approaching General Election on November 8 and the amount of time consumed in discussing political and legislative, as well as social and economic, issues.

Special interest has been directed toward the campaigns of those seeking seats in the next Ohio Legislature, the regular session of which in January undoubtedly will be one of the most important ever held by that legislative body.

It is important that questions of vital concern to the medical profession and allied groups be given the serious and unbiased consideration of public officials or candidates for public offices. The principles and policies of the medical profession should not be ignored by public office holders. The cause of scientific medicine and public health should be regarded by the office-seeker or office-holder to be just as vital to the public good and welfare as any other.

Medical organization as such is not, and should not be, political or partisan. It should not officially endorse or oppose individual candidates or take sides in purely partisan issues. However, physicians as responsible citizens should participate as individuals in public affairs, including those that are civic and political. They have a perfect right to sound-out candidates concerning their views on medical and health questions. They should feel free to campaign as individuals for those who are known to have well-informed and correct views on these questions. They need not be backward in passing on to their neighbors and friends information which they have relative to the fitness of the respective candidates. They should insist to the candidates themselves that they remain unpledged to dangerous and questionable proposals with a medical or health angle and that they give serious consideration to the views and opinions of the medical profession on medical and health questions, about which the medical profession is best informed.

Every physician between now and November 8 should consider it his individual responsibility to inform himself, if he has not already done so, concerning the medical and health views of candidates for public office. Likewise, he should make it his business to impress upon his local candidates that they look to the physicians among their constituents as the responsible and logical persons to whom they should go for advice and counsel on medical and health matters.

Naturally, it is the duty of every physician to cast his vote on election day and to remember that partisanship may be subordinated where the health of the public, the protection of scientific medicine, and the security of the medical profession is at issue.

The Profession and Workmen's Compensation

Almost every conceivable angle relating to workmen's compensation administration was analyzed and discussed at the recent meeting in Columbus of the International Association of Industrial Accident Boards and Commissions.

As might be expected, numerous medical problems incidental to the administration of a workmen's compensation law were considered.

The important role which the medical profes-

sion plays in the operation of the workmen's compensation system was emphasized repeatedly. Efficient, scientific medical care is most essential if the principle of workmen's compensation is to accomplish its purpose, it was pointed out. Moreover, it was declared that administrators of the law would be seriously handicapped without the sincere cooperation of the medical profession and unless they were accorded the benefit of honest, unbiased and competent medical counsel and advice in the adjudication of claims.

The prevailing opinion of those who took part in the discussion of medical questions was that the medical profession generally is performing the functions expected of it in an efficient and conscientious manner; that disabled workmen in general are receiving high-class medical attention, and that administrative boards and commissions are receiving cooperation and able assistance from physicians generally.

However, on several occasions criticism was voiced of those few physicians whose questionable tactics in connection with industrial accident cases have reflected discredit upon themselves and have jeopardized the standing of the great number of sincere, honest and ethical physicians who are rendering competent medical service and cooperating with the compensation commission.

There was a feeling that the responsibility for solving the problems arising from the questionable conduct of some of its members rests upon the shoulders of the medical profession itself. It was pointed out that administrative boards or commissions should hesitate to impose drastic rules and regulations in order to halt the practices of the unscrupulous physician since this also would tend to penalize the innocent physician. Likewise, it was suggested that commissions go to the courts in such cases only as a last resort. The hope was expressed that the medical profession would make every effort to meet these problems and not force administrators to use strong-arm methods.

In this connection, it was pointed out that commissioners must use common sense and sound judgment in dealing with medical questions. Medicine is not an exact science, it was declared by several commissioners, and each physician is entitled to have and to present his own opinion on any medical subject. The chief function of the administrative board, it was pointed out, in considering medical questions is to weigh the evidence and to be reasonably sure that the medical opinions presented are unbiased and not influenced by ulterior motives.

Ohio's Workmen's Compensation Law and the system which has been developed in this state to make it function are held in high esteem by commissioners and board mmebers from other states. The Ohio law was referred to frequently as the authority on controversial points. Ohio was mentioned often as a pioneer in attempts to perfect this type of social legislation.

It was intimated on several occasions that the medical profession of Ohio is in a most fortunate position with respect to the operation of the Workmen's Compensation Law. Several commissioners from other states indicated that much of their grief was due to the fact that the legislation in their respective states did not permit the free choice of medical service by the disabled workman and contained provisions which prevented harmony and cooperation between the administrative board and all parties concerned, including the medical profession. Under the Ohio system, many of these problems are minimized, it was pointed out.

These factors should not be lost sight of by the medical profession of Ohio. They are especially significant at this time when there is an indication that efforts may be made to have the next Ohio Legislature change materially various parts of the present compensation law.

Ohio physicians would do well to compare their present relationship with the administration of the Workmen's Compensation Law in this state with that of their colleagues in some of the other states. In all probability, such a study would emphasize the merit of the Ohio system, regardless of certain admitted imperfections. Tinkering with the Ohio law should be protested unless there is definite assurance that the proposed changes would improve the system which has for the most part been operating satisfactorily and effectively.

Health and Longevity of Doctors

Dr. E. B. Gillette, president of the Toledo Academy of Medicine, writing in a recent issue of the *Toledo Academy Bulletin* makes some timely and pertinent comments on a question of vital importance to every physician but which receives little thought on the part of the average practitioner.

"Physicians as a class take too little care of their own health", Dr. Gillette said in urging physicians to stop and consider the significance from their own standpoint of good health and physical fitness.

"They are constantly dealing with the health of others", he continued, "and are in daily contact with diseases and its exposure. We become thoughtless of the dangers of disease and even calloused in the handling of it, much as an oil driller becomes contemptous of the nitroglycerine he handles, and finally, in a careless moment, lets down his guard, with disastrous results. * * * The young practitioner, even more so than the older physician, should by all means take stock of his health, and his manner of living, even though he feels that nothing serious can happen to him. Do this before it is too late. Be consistent

and set an example to your patients, in the mode in which you live. Spend a little time developing a hobby, and consistently riding it. Do not let it overshadow your vocation, but use it to give the relaxation from your professional duties that you so much need."

The sound advice of Dr. Gillette is borne out by recent analyses of vital statistics as they apply to members of the medical profession.

One of the most comprehensive of these studies is that made by Frederick L. Hoffman, consulting statistician of the Prudential Insurance Company. Dr. Hoffman expresses regret in the report of his investigation at the lack of adequate, authentic statistical data on the mortality of medical men and makes a strong appeal that a thorough study of the problem of longevity in its special application to the medical profession be made, since, in his opinion, such "a study of the lives, the habits and the recreations of, say, one thousand men of mark in the medical world for the last quarter of a century would make an extremely valuable contribution to knowledge".

Summarizing some of the facts and factors revealed by his investigation of the question of life and death in the medical profession, Dr. Hoffman makes a number of enlightening, if not startling, disclosures.

He writes:

"When I set out on the presentation of this dissertation, I had hopes of being able to present the subject in a more finished and practically useful form, reflecting the results of medical learning and experience in the age-long effort to prolong the duration of human life, for it is in the lives of physicians and surgeons that we should find the answer to many of the most pressing questions that demand a solution. But the results, to my regret, are mostly negative. Medical men, in spite of their better knowledge and the immense benefits to mankind in the cure of sickness and the alleviation of pain, are themselves not benefited to the extraordinary degree as would naturally be expected. The death-rate of medical men is shown not to vary much from that of other professional pursuits, while it certainly falls below that of clergymen. * * *

"No career presents more strenuous mental effort, more exacting demands upon time, more sacrifice of means, more foregone leisure, than that of the doctor who takes his work seriously, and there are few who do not. No class of men renders a greater and more indispensable service to society than those who practice the art of medicine, in all its branches and selected specialties. Upon no group of men falls a heavier burden or a greater responsibility in peace and in war. And none has done more to advance the cause of a true civilization, in which the blessing of a long life and freedom from illness and suffering is made the supreme test of its attainment on the part of an ever-increasing proportion of mankind. Yet, as I have shown, the evidence regarding its own health and longevity is decidedly disconcerting, while suggestive of neglect that justifies the inquiry suggested."

The present-day physician should realize that the stress and strain of the average doctor's life bear heavily upon his average duration of life and his powers of disease resistance. He should keep himself adequately prepared physically to meet the enormous demands upon his mental and physical faculties. He must arrange, when possible, his daily routine so as to permit a careful budgeting of work and relaxation. He should point the way to longevity and health by example as well as precept.

Panaceas Never Cure

Writing to one of his friends in the Middle West quite recently on trends and future trends in the nation's Capital, a well-known Washington observer paints a vivid picture of the type of illogical and confused thinking which is taking place in an effort to solve some of the serious problems now confronting the nation.

"The last time you and I met," the Washingtonian informs his friend, "we talked of our economic educations and we both admitted they were faulty because they are based on what was written in books by professors who had retired to their cloisters like theologians of the Middle Ages. We had to unlearn much of what we had learned.

"A lot of fairly intelligent business men have not yet gone through the unlearning process. They are now flooding Washington with a tidal wave of panaceas. Everyone here gets them. There are long letters, booklets, mimeographed memoranda, plans, schemes. Some have a foundation of sense, but most are preposterous. All are born of a great yearning to be helpful but they betray too much intensive thinking upon too few assembled facts. They juggle simple conceptions fantastically. They are products of economic book-learning which was oversimplified."

There is a striking analogy between this situation and what has been taking place in the field of medicine for quite some time. In fact, formulating panaceas with which to cure at a single stroke imbalances and maladjustments in that field was becoming a popular activity until the 1929 bubble burst, which provided more worlds for the panacea-manufacturing industry to conquer.

One lesson of the present period of unrest and uncertainty undoubtedly will be that panaceas seldom, if ever, accomplish what is claimed for them. The medical profession has exploded that theory and now others are beginning to learn the same thing.

Choice of Treatment in Skin and Intra-Oral Malignancy. Its Relation to Surgery

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THIS paper is based upon a study of 1466 cases of skin and inter-oral malignancy treated in private practice during the past eighteen years by the author and his associate, Dr. H. N. Cole. The methods employed will be briefly described.

RADIATION

This is given by *X*-rays or radium. *X*-rays are used either unfiltered or by filtration through 0.5 mm. to 3.0 mm. of aluminum. Radium is employed in the following ways: (a) A half strength plaque two centimeters square, containing 10 mg. of radium element is used for surface application and can be fitted with several kinds and thicknesses of metal filters. (b) Radium needles 28 mm. in length, made of iridium and each containing 10 mg. of radium element, are used for interstitial radiation of tumors or can be arranged in various types of applicators for surface application. (c) Small radium needles 1.65 mm. in diameter, made of platinum and iridium with walls 0.5 mm. thick, are of varying lengths. They contain either one, two or three milligrams of radium element and are so constructed as to contain approximately 0.5 mg. of radium element per running centimeter of over all length. They are used chiefly for interstitial radiation of the larger tumors and are particularly well adapted for prolonged interstitial radiation of intra-oral lesions. They can be securely held in place by sutures and can be left in position for a week or longer at a time. The unusual filtration for the amount of radium contained eliminates Beta radiation and reduces inflammatory reaction around the needle to a minimum. They also are available for surface application in various types of applicators. For distant radiation, particularly of regional lymph glands, a large number of them can be arranged on the surface of a large moulded applicator of Columbia paste and held in position for one to two weeks. (d) Radium emanation in the form of gold implants are used for insertion into tumors and are particularly useful for treating inacessible lesions; for example, the base of the tongue and region of the tonsils.

ELECTRO-SURGICAL PROCEDURES

Electrocoagulation and electrodessication are effective agents in destroying tumor tissue and since the lymphatic channels are sealed by the heat generated in the tissues, the danger of releasing cancer cells is greatly lessened. The excision of tumor tissue may be accomplished by using the cutting current or diathermy knife. The actual cautery heated by electricity is used chiefly in destroying small growths and precancerous lesions.

OTHER SURGICAL PROCEDURES

Excision of primary tumor growths, depending upon the location, size, character of pathology, etc., is employed. Surgical removal of lymph glands for therapeutic and diagnostic purposes and block dissections in operable cases is of proven value. Plastic repair following cure of extensive and destructive lesions is of great value and is being more frequently employed in recent years. (Figure 1 and 2).

CURETTAGE

The curet is invaluable in the removal of tissue destroyed by thermal methods and is the best guide in determining the extent to which these destructive processes should be carried.

Experience has been that no one procedure is superior to all others. As a matter of fact, two or more methods have been employed in the treatment of many of our cases.

FACTORS INFLUENCING CHOICE OF TREATMENT

The factors that influence the choice of treatment in any given case may now be discussed:

1. *Early diagnosis.* In skin tumors, an early diagnosis is usually possible, for early recognition by the patient, as a rule, brings him to the phyisician in ample time to be cured. The pathology is on the surface and is accessible to treatment. The superior results obtainable in the field of skin cancer therapy is explainable on this basis alone.



Figure 1. Basal-cell carcinoma of nose, upper lip and cheek, showing resulting defect after cure by electrocoagulation, radium and actual cautery. Plastic repair by Dr. Vilray P. Blair, St. Louis, Mo. Has remained well over eight years. Referred by Dr. Edwin Season, Cleveland.

Read before the Surgical Section, Ohio State Medical Association, at the 86th Annual Meeting, Dayton, May 3-4, 1932.

From the Department of Dermatology and Syphilology, School of Medicine, Western Reserve University.



Figure 2. Squamous-cell carcinoma of the mouth. Treated by X-ray, electrocoagulation and excision with the diathermy cutting current. Plastic repair by Dr. F. S. Gibson, Cleveland. Has remained well over four years to date.

2. *Age and Sex Factors.* In this study of 1466 cases, the age incidence increases each year until the normal span of life has been reached. This holds true for melanomas, basal cell carcinomata, squamous cell carcinomata of the skin, mouth, lip and penis. In the entire group the incidence was as follows:

1- 9	years	3 cases
10-19	"	4 "
20-29	"	14 "
30-39	"	90 "
40-49	"	180 "
50-59	"	359 "
60-69	"	485 "
70-79	"	279 "
80-89	"	48 "
90-99	"	4 "

It will be noted that approximately one-third of all the cases occurred between the ages of 60 and 69 years, inclusive. In comparison with population statistics, it is found that the older the individual, the greater the liability to skin malignancy.

Changes in the skin resulting from senescence, such as atrophy of the sebaceous and sweat glands causing skin dryness, loss of subcutaneous fat and elastic fibers, and sclerotic changes in the derma, while not considered as precancerous lesions, nevertheless predispose the individual to external irritation and the production of senile verrucae and keratoses. From the standpoint of the incidence of cancer of the skin, the anatomical and physiological age of the individual is of greater importance than his chronological age.

Malignancy of the skin and intra-oral cavity predominates in males. In this series there were 863 males and 603 females. Occupational hazards and exposure to weather probably account for the male majority. The average age of the females was somewhat less than that of the males.

It is well known that the skin of elderly persons will tolerate radiation better than that of young persons. Also, as a general rule, the malignancies of youth are more radiosensitive and, at the same time, more malignant than those of adult years.

3. *Anatomical Considerations.* In malignancy of the skin of the face, certain underlying anatomical factors are of great importance in selecting the proper procedures, for in certain locations the underlying structures increase the dangers of the malignancy. This was brought out recently by Snoke. For example, the skin of the inner canthus is separated from the ethmoidal cells by only three millimeters. Once these cells are invaded, the likelihood of cure is greatly lessened. The bone is very close to the surface over the malar prominence and infiltrating lesions may quickly involve the periosteum and bone. This is true also of the area just anterior to the external auditory canal, where the majority of lesions are of the squamous cell infiltrating type.

Underlying fascia, such as is found in the temporal region, once involved, presents a serious complication which is nearly always accompanied by involvement of the outer table of the skull, the formation of a large sequestrum and an almost hopeless situation.

The dense underlying integumentum, as found in the region of the angulae alae nasi, may present problems which are extremely difficult. In this location, healing following radiation is accompanied by a dense fibrosis, with often an insufficient blood supply to cause healing on the surface. Then again, if treatment insufficient to destroy all the cancer cells has been given, the recurrence is extremely radioresistant. This same

type of underlying structure is found on the scalp, where infiltrating lesions present the same possibilities.

Underlying cartilage, as found in the ears, eyelids and nose, is very close to the surface, and once involved, may mean extensive or complete destruction of the entire cartilage before the lesion is brought under control.

Lesions below the lobe of the ear, overlying the parotid gland, are likely to be squamous cell in type. Involvement of the gland and the lymph nodes may take place in a short time.

New growths involving the vermilion border of the lower lip are invariably of the squamous cell type. They show an early tendency to metastasize. The rich lymphatic drainage and the mobility of the area increases this danger.

Lesions involving the base of the tongue, the region of the tonsils and the posterior portion of the floor of the mouth, being difficult of access, are always serious, even if seen comparatively early. Fortunately they are generally radiosensitive. On the other hand, tumors of the anterior tongue are usually radioresistant.

Squamous cell carcinoma on the dorsum of the hand may present serious difficulties because of the underlying tendon sheaths, and because of the tendency to early involvement of the draining lymph glands.

Careful consideration of the type of therapy is necessary also for cancers developing upon an already altered skin. For example, those appearing in old scars from any cause, and in particular those from lupus vulgaris, *X*-ray burns, gummas and varicose ulcers.

4. *Amount and nature of previous therapy.* Great care must be exercised in the nature of the therapy to be used if the lesion has been previously treated. If failure has resulted, for example, from previous radiation, the tissues will probably be resistant to further treatment of this type, and either thermal destructive measures or excision must be used.

5. *Biopsy examination.* Experience has shown that there are wide differences in the therapeutic problem presented by the different types of epidermoid cancers. Pathological examination is our only means of determining the potential malignancy and the exact nature of many of these growths. It often is possible, by such an examination, to estimate the degree of radiosensitivity. This is evidenced by the degree of increased metabolism of the tumor cells, as shown by active mitosis and increased vascularity of the tumor and the surrounding tissue. The degree of cell differentiation is also of great importance, as brought out by Broders and others. The origin of the tumor, whether from prickle cells, basal cells, epithelium of sweat or sebaceous glands or hair follicles, or from connective tissue or pigment forming cells, is of fundamental importance in determining the amount and kind of treatment to be administered.

The taking of biopsies is criticized by certain workers who claim that the opening of blood and lymph channels helps to spread the neoplasm. This view might justly be taken in regard to certain tumors, especially sarcomata, but certainly this danger with regard to carcinoma of the skin is not so apparent, especially if the area is immediately cauterized after the biopsy. In many instances, particularly in early lesions and also where recurrences have taken place, histological examination of excised portions, removed of course under proper precautions, is necessary in determining the exact nature of the growth. In the interests of our patients, and for the advancement of our knowledge, the advantages greatly outweigh the disadvantages. Thus we have, many times on biopsy examination, found that a tumor was made up of prickle cells instead of the expected basal cells. Naturally this made a change in our therapy.



Figure 3. Basal-cell carcinoma of eyelids and side of the nose. Result after treatment with radium and X-ray. Has remained well over eight years. Referred by Dr. Wm. E. Bruner, Cleveland.

THERAPY

1. *Basal cell carcinoma.* 903 lesions out of a total of 1554 of all types were basal cell carcinomata. (Figures 2 and 3), In over 90 per cent, they were located on the face, showing a definite predilection for the central portion, that is, on the nose, cheeks, about the eyes, and on the forehead and temples. They may, however, develop on any part of the body surface. Development may be from normal skin, but usually some previous lesion precedes it. Senile keratoses are the most common forerunners. Occasionally we find them from degeneration of old scars. We have seen many malignancies secondary to the constant irritation of nose glasses. Growth and development are usually slow, sometimes extending over a period of years. They show a strong tendency to become localized, and they do not metastasize early. Uncomplicated



Figure 4. Baso-squamous-cell carcinoma of outer canthus, upper eyelid, evebrow and temple. Three years later developed metastasis to preauricular gland. Treated by radium and X-ray. Has remained well over seven years. Referred by Dr. C. W. Thomas, Warren, Ohio.



Figure 5. Baso-squamous-cell carcinoma of the right cheek, showing method of interstitial irradiation with small radium needles by the Regaud and Cade technic.

basal cell lesions are quite radiosensitive in general, but in the region of the angulae alae nasi are less so. Radiation with either radium or *X*-rays, or a combination of the two, is practically always used. If the tumor is of considerable size, it is destroyed by electrocoagulation or electrodessication and the base carefully curetted to remove as nearly as possible all the tumor tissue prior to the use of radiation. There is surprisingly little scar as a result of this therapy, hence the cosmetic results are usually very good. However, should there be a well developed involvement of the cartilage of the eyelids, nose or ears, surgical excision by the scalpel or by the cutting current followed by irradiation, is the treatment of choice.

If the lesion has recurred following radiation, one resorts to destruction of the area by the cautery of electrocoagulation or again it may be feasible to excise it. If the cancer has produced excessive erosion and destruction of deeper structures, some type of surgical plastic repair may be necessary following its cure by some combination of the above measures. However, such repairs should not be attempted for a year or more in order to be reasonably sure that a recurrence will not take place.

2. *Cystic basal cell carcinoma.* This is simply a type of basal cell tumor with cyst formation. They are not uncommon. They rarely attain a size much larger than a castor bean and seldom ulcerate until late. This type is also radiosensitive and responds well to radium or *X*-rays. Individual lesions may also be treated with electrodessication or the actual cautery. There were 23 cases of this type in our series.

3. *Multiple superficial benign epithelioma.* There were 27 cases of this type in our series. This condition is also described, though incorrectly, under the term Bowen's precancerous dermatosis, or Bowen's disease. The lesions arise from normal skin and are usually multiple and, clinically, may resemble somewhat psoriasis, eczema or lupus erythematosus. They often appear as a well defined plaque, with a slightly elevated, somewhat crusted and indurated periphery, and showing a reddish, slightly scaly, atrophic center. Microscopically, they are basal cell carcinomata. Because they are usually quite superficial and rarely hypertrophic in character, they often are easily cured by superficial dessication and curettage. In the early lesions, lightly screened radium may be used and also deep freezing with carbon dioxide snow. However, carbon dioxide snow therapy is not to be recommended for general use in the treatment of malignancy.

4. *Baso-squamous cell carcinoma.* (Figures 4 and 5). Statistics vary with different writers, but about 10 to 15 per cent of all skin carcinomata belong in this group. Due to stimulation in the course of inadequate or insufficient and prolonged treatment, a basal cell tumor may change to the squamous cell type. Histologically, one finds typical basal cell carcinoma in one part of the tumor and typcial squamous cell carcinoma in another portion. They usually show only a moderate tendency to metastasize, but are relatively radioresistant. Electrocoagulation alone or followed by radium, depending on the case, is usually successful. Biopsy examination is imperative in order to determine the exact nature of the lesion.

5. *Squamous or prickle cell carcinoma.* (Figures 6, 7 and 8). Four hundred and ninety-nine out of 1554 lesions were of this type. The principle areas attacked were:

Lower lip	149	cases
Intra-oral	75	"
Hands	51	"
Neck	42	"
Ears	36	"
Genitalia	18	"

While any area of the skin may be the site of this type of malignancy, the above regions are the most frequently involved. On the skin of the face and hands, senile keratoses and other changes due to senescence are the predisposing

factors in the majority of cases. Chronic irritation in various forms is responsible for most of the lesions on the lip and in the mouth. Those squamous cell lesions occurring in young individuals appear to be the most malignant and at the same time more radiosensitive than those seen in elderly persons. They are characterized by rapidity of growth and a tendency to early metastasis.

All the methods of treatment previously described are used in treating squamous cell carcinoma, and in a combination of two or more have been found preferable to relying on any one procedure. It must be remembered that because they are not as radiosensitive as basal cell carcinomata, larger doses are required and the possibility of metastasis must be constantly kept in mind. Electrocoagulation and curettage, followed by radium or *X*-rays, is usually the routine in those lesions on the skin which are not complicated by metastases.

Malignancies of the vermilion border of the lips and intra-oral cavity are, with very rare exceptions, squamous cell in type. They generally develop rapidly and may metastasize early.

Involvement of the lower lip predominates in males. In this series of 149 cases, it was 25 to 1. Chronic irritation from tobacco smoking was present in 128 of the male cases. The majority had outdoor occupations. Moreover, exposure to weather, particularly sun and wind, is an additional predisposing factor. In elderly persons, particularly blonds, carcinoma of the lip may develop on senile keratoses in non-smokers.

As regards the treatment of lip carcinoma, there are still considerable differences of opinion held by various men. The surgeon will, as a rule, prefer excision, but surgical excision is not practiced to the extent that it was formerly, because increasingly excellent results from improved technique are being obtained by the use of electrocoagulation and radiation. It was our custom several years ago to treat most of these cases by destroying the lesion with electrocoagulation, as recommended by Clark and Pfahler, followed by surface applications of radium or *X*-rays. The results were quite satisfactory so far as elimination of the disease was concerned, but in the cases showing involvement of the lip, the loss of some normal tissue produced during coagulation resulted in more or less deformity and the dribbling of saliva, was very objectionable. The selective action of radium and *X*-rays in "picking out" only the tumor tissue gives a much better functional and cosmetic result. The use of the small radium needles in this connection is becoming more and more popular. They are inserted through the normal skin surrounding the lesion and left in place for from five to nine days, depending on the extent of the involvement. There is surprisingly little local reaction, practically no discomfort,

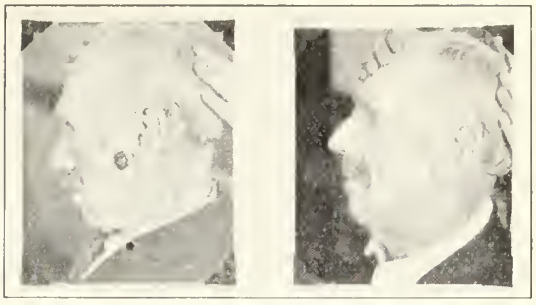


Figure 6. Squamous-cell carcinoma of left cheek. Treated by electrocoagulation, curettage and radium. Has remained cured over seven years.

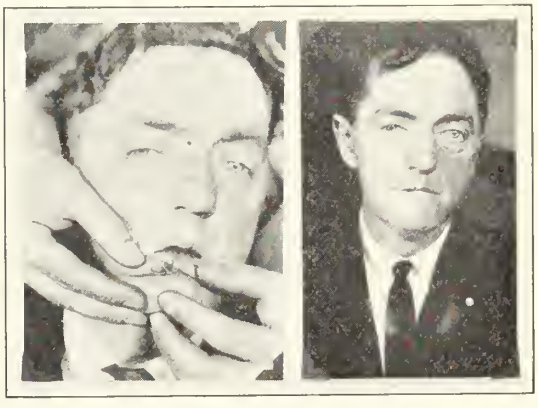


Figure 7. Squamous-cell carcinoma of lower lip treated by electrocoagulation, radium and X-ray. Cured over nine years to date. Referred by Dr. J. H. Krape, Kent, Ohio.

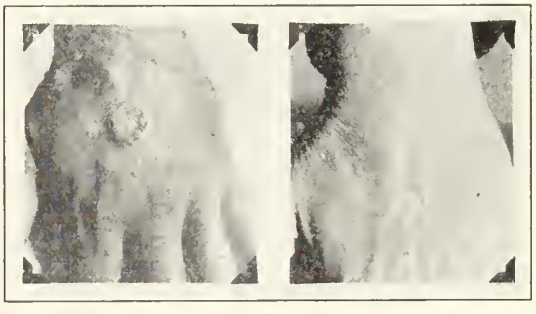


Figure 8. Squamous-cell carcinoma of dorsum of left hand treated by electrocoagulation, curettage and X-ray. Well over three years to date. Referred by Dr. Walter H. Rieger, Cleveland.

healing is prompt and without the caustic effect commonly seen in surface applications of radium.

The very early small lesions are usually destroyed by the actual cautery or coagulation, followed by surface radiation.

The possibility of metastasis to the submental and cervical glands presents our greatest problem. If careful examination reveals nothing that is suspicious and the lesion is early and small, we give no treatment to these areas, but we re-examine them at frequent intervals over a period of years.

If no involvement of glands can be made out clinically, but the lesion is of considerable size or has been present for a long time, we give a course

of filtered *X*-ray treatment to the area for prophylactic reasons. Our experience has shown that this conservative attitude is reasonably safe. We believe with Quick and others that routine dissection of the glands in all cases of carcinoma of the lip is unwarranted.

If there is unquestionable or suspicious glandular involvement, we advise later, dissection of the glands in all operable cases, preceded and followed by filtered *X*-rays treatment or the use of a radium pack, employing a Columbia paste collar in order to obtain uniform and proper distance.

Extensive, inoperable involvement of the glands should be treated palliatively with radiation.

In our series there were 75 cases of intra-oral cancer treated. While Ewing's statement that "intra-oral cancer is so closely dependent on bad teeth, tobacco and syphilis that if these conditions were removed, this group of cancers would disappear", is perhaps too dogmatic, still these factors account for probably over 90 per cent of the cases.

Improvements in technique, in the use of radium therapy in the past ten years, has changed our conception considerably concerning the treatment of intra-oral cancer. Formerly the first question that arose was: Is the growth removable? If it was, surgical excision was done. The results were dependent chiefly upon the size of the growth. Local recurrences were not uncommon and the percentage of cures by this method is probably no better today than it was twenty years ago. Electrocoagulation and excision of suitable lesions by means of the diathermy cutting current have improved the results greatly and they remain today of proven value in suitable cases. The initial efforts with radium in this location were not very encouraging. However, due to the splendid persistent work of Quick in this country, of Regaud in France, and Cade in England, the superiority of radium treatment, so far as the primary growth is concerned, has been demonstrated beyond much doubt. The treatment is safe and does not result in mutilation. Even in many cases where the radium treatment has failed, surgery can still be resorted to and sometimes an inoperable growth becomes operable because of the radiation. As a result of the increasing number of successful results in eliminating the primary growths by the use of radium, we now employ this method in practically all lesions of any considerable size. In some of the very early smaller lesions, particularly on the mucous membrane of the cheeks, lips and anterior portion of the tongue, electrocoagulation is still used with very satisfactory results.

The improved Regaud and Cade technique of radium therapy is based upon the principle of prolonged radiation with small quantities of radium, well screened, in order to eliminate all of the irritating Beta rays. This eliminates also the painful slow healing radium necrosis that often resulted from the use of large amounts of radium insufficiently screened and given in a short time. The new slower method has the added advantage of irradiating the cells during the successive periods of mitotic division, at which time they show the greatest radiosensitivity. For this purpose the small radium needles previously described are used. Being available in different lengths makes the treatment flexible and adaptable to various sizes and locations of lesions. The needles are inserted into the normal tissue surrounding the lesions and are sutured in place in the healthy tissue. Inserted from opposite directions in pairs and tied together, in some locations, holds them in place without suturing. They are left in from five to nine days, depending upon the character and size of the growth.

This method may not be feasible in lesions of the palate, uvula, pillars of the fauces, base of the tongue and the tonsils. These areas are often inaccessible from the standpoint of the proper distribution of the needles and of suturing them in place. Here, radon, in the form of gold implants, which do not need to be removed, are inserted by means of trochars, which are especially adapted for this purpose.

The walls of these implants are 0.3 mm. thick and nearly all of the Beta rays are thus eliminated. They have, for this reason, largely replaced the glass implants. Various sizes containing from one to three millicuries are available according to the indications. Lesions in the posterior portion of the mouth are liable to be more radiosensitive than those in the anterior portion. However, because of the difficulties in estimating accurately the extent of the growth in these locations, insufficient irradiation most often accounts for the failures in controlling the primary growth.

TREATMENT OF METASTASES

Let us now consider the problem of the best possible treatment for the prevention or cure of malignant deposits in the cervical lymph glands. Metastases, even long after the disappearance of the primary lesion, are sometimes seen. Clinical examination often fails to reveal the presence of this serious complication. The following procedures have been adopted from the experience gained from our own good and bad results and partially from the reports of others, chiefly of Cade and Regaud.

In intra-oral lesions, which are very small and which have been treated early, showing no clinical evidence of involvement of the cervical glands, we usually treat the primary lesion only, giving no therapy to the glands. If, however, the primary growth is rapid in development and has attained considerable size, the glands, although not palpable, are given a course of filtered *X*-ray treatment. But if the glands are palpable and operable, operation is clearly indicated in all cases. This should consist of nothing short of complete block

dissection and should be bilateral if both sides are involved. It is advisable to wait until the primary lesion is well healed before this is done, inasmuch as the glands act as a filter to catch cancer cells. Approxmately three to four weeks after the operation, in order to insure sound healing, irradiation of the area is carried out, providing careful histological examination of all of the glands has revealed malignant involvement. This is best carried out by means of radium, using a Columbia paste collar to obtain proper and uniform distance. The small needles are placed on the surface of this applicator, equidistant from each other. Usually 40 to 75 milligrams are required and the treatment requires on an average of ten days to two weeks. In inoperable cases where there is a fixed mass of glands involving the deeper structures in the neck, radium or heavily filtered *X*-rays should always be used. This palliative procedure may prolong life for as long as a year or more.

6. *Melanocarcinoma.* There were 22 cases in our series. The diagnosis in 16 of these cases was confirmed by histological examination. Melanomas are the most malignant of all skin tumors because of the early tendency to metastasis, and once this has taken place the patient is doomed and any attempt at therapy only tends to hasten the end.

If no metastases are demonstrable, the therapy of choice is surgical removal, followed by a course of filtered irradiation to the area. Removal may be carried out by wide excision with the scalpel or by the cutting current and should be deep enough to include the subcutaneous fat and fascia. Also electrocoagulation in early or suspicious lesions, if thoroughly carried out, is satisfactory. Anything short of complete elimination is most dangerous and histological examinations for diagnosis are not to be made from partially excised portions.

Melanomas usually develop from pigmented moles of the flat black, or slate colored varieties, and generally the degeneration can be traced to irritation or trauma of some sort. If located in areas where such irritation may result, we strongly advise their wide removal by electrosurgery, or excision with the scalpel, before there is evidence of any change in them.

7. *Lymphosarcoma.* There are five cases in our series. They are a slowly malignant process, but life may be prolonged for long periods by the use of radiation. They are the most radiosensitive of all tumors so far considered. Large masses of tumor tissue can be made to disappear in a comparatively short time, but this does not prevent the development of metastatic tumors elsewhere. The skin of the face and scalp are most commonly attacked, while metastatic growths appear in the cervical, axillary and inguinal lymph glands, along with deep involvement of the mediastinal and retroperitoneal glands. After repeated irradiation, they finally become radioresistant and the patient dies of the breaking down tumor masses, cachexia, anemia and intercurrent infections.

SUMMARY

From the experience gained in the treatment of 1466 cases of malignancy of the skin and intra-oral cavity, we attempt to show that the choice of the treatment to be employed is dependent upon several factors, if satisfactory results are to be expected.These include early diagnosis and biopsy examinations if it is found necessary to determine the exact nature of the growth and in order to estimate the degree of radiosensitivity; the age and sex factor and the importance of taking into account the location of the lesion and the underlying anatomical structures are shown; the amount and nature of previous therapy and the problems attendant upon the treatment of recurrences are emphasized.

The therapy recommended is then discussed from the standpoint of the various pathological types of malignancy.

We point out the comparative ease of eliminating early basal cell and squamous cell carcinomata of the skin with the use of radium and *X*-rays. More advanced or recurrent lesions require some combination of radiation, electrosurgical procedures and surgical excision.

Well developed baso-squamous cell carcinomata and squamous or prickle cell carcinomata present the greatest difficulties because of the possibility of metastasis. Greater dosages of radiation are required on account of their being less radiosensitive and a combination of radiation and surgical procedures are practically always necessary. Metastatic growths are always primarily a surgical problem requiring block dissection of the glands. The inoperable cases are treated by radiation. The problem of plastic repair of resulting defects opens to the surgeon an important and constructive field of work demanding exceptional skill and patience.

Melanocarcinoma is probably a surgical problem requiring wide and deep complete removal. Exceptionally very early or suspicious lesions are destroyed by electrocoagulation. Follow-up irradiation of the area is given in all instances. If metastases are present, any form of treatment tends to hasten the fatal issue.

Irradiation, while not a cure, prolongs life for long periods in cases of lymphosarcoma.

1352 HANNA BUILDING.

Lepers living at the National Leper Home, Carville, La., publish a weekly newspaper, entitled the "Sixty-Six Star". It averages four pages and contains news concerning the residents of the colony.

Causal Factors in Posterior Positions of the Occiput

William D. Porter, M.D., Cincinnati, Ohio

SINCE posterior positions are variants of the vertex presentation a study of causes is incomplete if it fails to account for the presentation.

In the earliest available literature it seems to have been assumed or tacitly agreed that the head occupied the fundus of the uterus for about the first seven months of gestation. Towards the end of this period the fetus was supposed to reverse its position, the head approaching the orifice and the breech going up into the fundus. This was accepted belief until perhaps two hundred years ago. About that time Smellie, Baudeloque and other clinicans disputed the dictum and submitted facts which were incompatible with the long accepted belief.

After a time the gravitational theory was evolved and it found ready acceptance. It assumes that the fetus is suspended in the amniotic fluid by the cord and that the cephalic extremity, being the heavier, gradually gravitates to the uterine orifice and the breech necessarily goes to the fundus.

Later this theory was assailed by Dubois. He denied that the fetus is suspended by the cord. And he further claimed that if it were possible for it to be suspended in this manner the head would not necessarily and uniformly descend to the lower position. Dubois advanced the extraordinary theory that the fetus assumed the vertex presentation through instinctive, voluntary efforts. He believed it was influenced by the same urge that guides the bird in fabricating its nest. Cazeaux observed that Dubois displayed much more ability in destroying theories than in creating substitutes. Cazeaux also made the shrewd observation that all investigators had erred in confining their study to the form and structure of the fetus and pointed out the importance of considering the influence of the various maternal structures.

At this juncture Sir James Y. Simpson applied his clear logical mind to the problem. His profound knowledge of physiology enabled him to correct the palpable errors of Dubois and to preserve and largely recast those portions of Dubois' contention which were of value. But first Simpson made a complete review of the gravitational theory and showed that it embraced assumptions which were at variance with well known facts. He reviewed Dubois' ideas of voluntary movements showing that some arguments were based on sound physiology. He then cleverly substituted his own conception of reflex motion on the part of the fetus which, briefly, is as follows: If the presentation is not the best, mechanically, the fetus will be subjected to pressure which, causing discomfort will excite reflex or excito-motary movements and these will persist until a position affording maximum comfort is reached. If displaced from this favorable position the same process will be repeated until the best position is again attained.

During his lifetime no one attempted to refute the arguments of Simpson. After his death Matthews Duncan made an elaborate and determined attack and sought to establish again the old theory of gravitation. In this he was largely successful.

Then for many years nothing was written on this subject and it remained for the late William Gillespie to thoroughly review the arguments of Simpson and of Duncan and to point out the strong and the weak points of both sides. While siding largely with Simpson, Gillespie showed that his theory was vitally weak in that his explanation of reflex movements was too general. Moreover there was nothing to show how the fetal movements resulted in the favorable presentation nor just what forces were active in maintaining this presentation.

Gillespie then proceeded to show that with the breech presenting, extension of the legs tends to displace the breech and to substitute the head. On the other hand, with the head presenting, these movements tend to prevent a change in presentation. And finally, as the fetus grows the time comes when it is still possible to shift from breech to head but not from head to breech. I quote as follows from Gillepsie's article in the *Lancet-Clinic* of 1908:

"With the breech over the pelvic brim, the thighs flexed upon the abdomen and the legs upon the thighs, the child lies with its back to the mother's left. In this attitude a sudden kick will bring the feet against the uterine wall over the right flare of the ilium. As the uterine wall is practically a fixed point, the result of such a kick will be to raise the breech from the lower uterine segment and move it upward along the left side of the uterus. The upward movement of the breech will raise the head into contact with the fundus and drive it over towards the right horn of the uterus, as seen in Fig 2. A repetition of the kick will bring the feet in contact with the left side of the uterus over the left flare of the ilium, and the breech will again be raised towards the left horn; but the head coming squarely against the right side of the uterus, may refuse to budge, when the spine, feeling the antagonistic forces of propulsion and resistance, will flex until its curve conform with that of the fundus. In this attitude the upward force applied to the breech, will transmit to the head, through a circuitous route, a downward force, and the child is brought into

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Fig. 1



Fig. 2

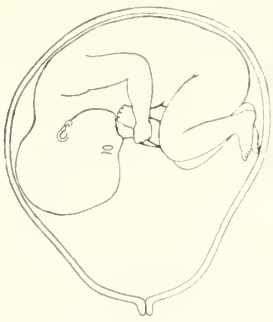


Fig 3

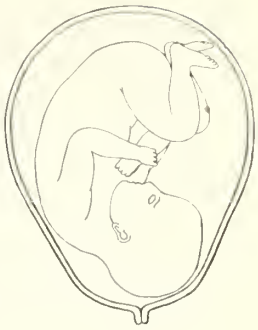


Fig. 4

the attitude shown in Fig. 3. Having arrived at a position where the head is upon a lower level than the breech, the difficulty is over, for a repetition of the fetal motions, or the occurrence of a rythmic uterine contraction, will complete the version.

"I do not mean to imply that this spontaneous fetal version occurs in just so many steps, or that every attempt would prove successful, for some do not; but the mechanical arrangement of the fetus is such as to favor strongly such a mechanism, and that is all that can be said of any mechanism purporting to deal with obstetric problems. The test would, of course, come at the time when the long axis of the child was approaching the transverse diameter of the uterus, and repeated efforts on the part of the fetus may sometimes fail, but that such mechanism is usually successful the large preponderance of vertex labors amply testifies.

"Having noted the probable effect of fetal movements upon the child when the breech occupies the lower zone of the uterus, let us look at the probable influence of fetal movements upon its attitude when the head presents. In this position (Fig. 4) the head will fit pretty accurately the lower uterine zone, and ordinary movements of the lower limbs will not tend greatly to displace it. When the child kicks out with force, the head will remain in the lower uterine zone and the force of the movement will simply tend to throw the breech of the child towards the opposite side of the uterus. This will bring the body, throughout its entire length, against the opposite wall of the uterus from which it will rebound towards its original position. In an earlier period of fetal development the more globular shape of the organ and the more flexible condition of the spine would tend, if the kick were repeated with the feet in contact with the fundus, to force the head upward; but the configuration of the organ, as it develops, will tend to preserve the power of changing a breech to a vertex presentation to a much later period than of a vertex to a breech."

After the vertex presentation becomes permanent and before the final position is determined there is a varying interval during which the child is likely to make many rotary movements on its long axis. Such movements are likely to vary directly with the quantity of amniotic fluid and inversely with the size of the child. These movements are due to reflex efforts on part of the child and to the changing attitudes of the mother. The numerous twists sometimes seen in the cord may be due, in part at least, to these rotary movements.

As gestation proceeds these movements gradually diminish. The fetal mass increases faster than the capacity of the uterus. There is a relative decrease in the volume of fluid. There comes a time when there is very little rotary movement on part of the child. It is this final fixed attitude which determines position.

The position is likely to be anterior if the long axis of the uterus corresponds with the axis of the superior strait. There are several reasons for this tendency. The portion of the fetal ovoid formed by the back is well adapted to fit snugly into the anterior portion of the uterine wall, particularly with the mother in the upright position. Anterior engagement occurs more easily as the broad occiput has ample space on each side as it moves down behind the pubes. When entering behind, the broad end of the head may find adjustment difficult as it enters between the promontory and the lateral pelvic wall. Also in anterior positions the head becomes, in a measure, fixed as soon as engagement begins because of the increased flexion. In the beginning of posterior engagements the tendency to become fixed is not so marked. The anterior pole does not wedge against the pubes until the occiput has made some progress down the long sacral arc against which it must move. Hence in the beginning of engagement there is a chance that the process may be interrupted. If so, rotation is possible resulting in anterior engagement.

These minority cases of posterior engagement give little trouble, provided there is no disproportion. They merely require a little more time.

Many amateurish methods of artificial rotation are developed in this class of cases. Methods ridiculously inadequate in difficult cases are successful in these simple cases that need no assistance.

As probable causes of posterior positions, text books recite a number of abnormalities such as tumors and pelvic deformities. No attempt is made to show why.

There is one abnormality, never mentioned in the books, which is a frequent cause. This is an unusual pelvic tilt—an excessive lumbosacral angle. Years ago when large families were not

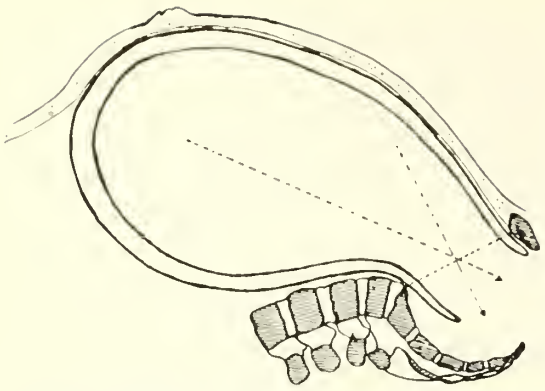


Fig. 5. Excessive lumbo-sacral angle showing posterior obliquity of uterus.

uncommon I frequently noted posterior positions in successive pregnancies of the same woman. Hunting for some peculiarity common to all, I noted that sway-backed women were likely to show a high percentage of posterior positions. The reason is easy to find. Anterior engagements are difficult and posterior engagements are easy. Anterior engagements are difficult because the axis of the uterus diverges from the axis of the inlet. (Fig. 5). It is difficult and at times impossible for the head to flex sufficiently to get down behind the pubes. Frequently the difficulty is increased by the prominence of the lower lumbar vertebra. (Fig. 7). This means that for practical purposes the posterior end of the conjugate is elevated to the upper edge of the vertebra since it stands out further than the promontory. Also it is found in these cases that the



Fig. 6

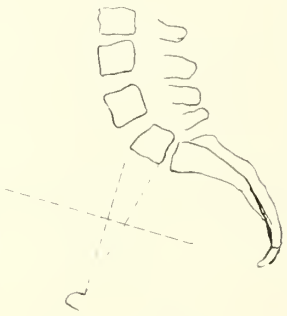


Fig. 7

(6) Normal lumbo-sacral angle. Tracing from X-Ray plate.

(7) Excessive lumbo-sacral angle. Tracing from X-Ray Plate.

backward curve of the lumbar and lower dorsal spine is increased and this throws the fundus further back. This increased curve is necessary to preserve the body balance.

Excessive lumbo-sacral angle is often found in short heavy women.

The diagnosis is not difficult. Either inspection or palpation is conclusive. With the patient on the table the hand is easily slipped under the lumbar region, and often the space is several inches.

While posterior engagement is easy dystocia is frequent. The tilt of the pelvis with lowering of the pubes makes descent difficult. A tedious first stage is the rule. In the second stage, as the head descends, it is carried still more posterior to the uterine axis. At times the head is forced into the transverse while it is still high. Forceps applied at this stage require judgment and skill. Anterior rotation is impossible until a lower level is reached.

The American Journal of Obstetrics for 1885 contains an article by Dr. John Ferguson of Toronto on causes of posterior positions. In reviewing the literature he states that Uvedale West and McDonald were the only writers who had advanced views of any importance. The former attributed posterior positions to early and great extension of the head. The latter believed they were due to heads disproportionately large for the pelvic cavity. This unpromising introduction is easily forgotten in a perusal of what follows.

Ferguson advanced the theory that, with an anterior presentation, an unduly prominent lumbo-sacral angle favors the rotation of the occiput backward instead of forward. He then goes into a tedious consideration of mechanism to explain this backward rotation. It is difficult to follow his explanation and one is in doubt as to the correctness of all the details. The important fact is that he is trying to explain what he had actually observed. He studied a number of cases in which the position was anterior but the head was not engaged. Owing to excessive lumbo-sacral angle it was impossible for engagement to take place with the occiput anterior. He watched these cases and noted that the head was gradually forced into the transverse position and on into a posterior position before descent was possible. In concluding his article he promised to report a series of cases. If such report was made it was not likely published as a careful search for it is unsuccessful.

So far as I am able to determine nothing further appeared on this subject for nearly a half century. In an unpublished paper Wm. Gillespie goes thoroughly and convincingly into the mechanism of this secondary posterior position, the result of an excessive lumbo-sacral angle. This paper was read before the Cincinnati Obstetrical Society, probably in 1923. He had observed this mechanism in a number of his own cases. He had noted some cases of peculiar dystocia, partly due to excessive moulding in neglected cases to which he was called in consultation. While he was obstetrician to the Cincinnati General Hospital he had a large number of casts made of heads which

showed the peculiar moulding due to posterior positions.

Dr. Henry L. Woodward who succeeded Dr. Gillespie was familiar with the ideas of Dr. Gillespie and has observed a number of these secondary posterior positions. Many of these observations have been verified by *X*-ray pictures. I asked Dr. Woodward to give me a brief resume of his observations and quote him as follows:

"From long experience I am convinced that the pelvis, even of normal measurements, that has an abnormal backward tilt, or in other words, an increase of the sacro-vertebral angle will allow the head to enter more readily if the occiput is posterior than if it is anterior. I have observed many instances in which the head presenting at the brim in the occiput anterior position, primarily, has rotated posteriorly to enter such a pelvis. This secondary position occurs, at times, on either side of the pelvis but is much more frequent on the left side for the following reasons:

"It is generally conceded that most left sided presentations of the occiput are anterior and most right sided presentations are posterior because of the greater frequency of right obliquity and torsion of the uterus.

"In the presence of an increased sacro-vertebral angle the occiput at the brim in the L. O. A. position, is driven against the low placed ramus of the pubis on the left side of the symphysis and deflected backward so that it can slip under the pelvic brim to the left of the prominent sacral promontory. It then descends to the pelvic floor as a secondary L.O.P. position and the remainder of the mechanism is typical of a primary L.O.P. position.

"I have a large number of case records showing this mechanism in detail, as in the following: Mrs. A. J. S. primipara, aged 27, delivered Oct. 22, 1931. (Fig. 8). Examination one week before delivery shows head above the brim L.O.A. *X*-ray examination confirms this and shows a marked increase in the sacro--vertebral angle. A note was made at the time that the occiput would probably come posterior as it came down. One week later on going into labor the membranes ruptured early, at 5 a. m. At 8:45 a. m. head still high and in L.O.A. position. Dilatation very slow but at 8:45 p. m. head is engaging in brim in L.O.P. position and two hours later patient was delivered by forceps rotation of the posterior occiput."

I quote these authorities on secondary posterior position because I have had a very limited experience with the mechanism. A good many years ago I encountered serious difficulties in these cases which failed to engage anteriorly, owing to excess of the lumbo-sacral angle. I soon adopted the expedient of making a thorough bimanual examination with complete general anesthesia. This is done about a month before term, in all cases in which engagement cannot be effected without an anesthetic. By dilating the vaginal outlet manually it is easy to introduce the half hand or, if necessary, the entire hand. In this way the amount of difficulty in engagement can be pretty well determined. Also the problem of disproportion can be made out with a fair degree of accuracy.

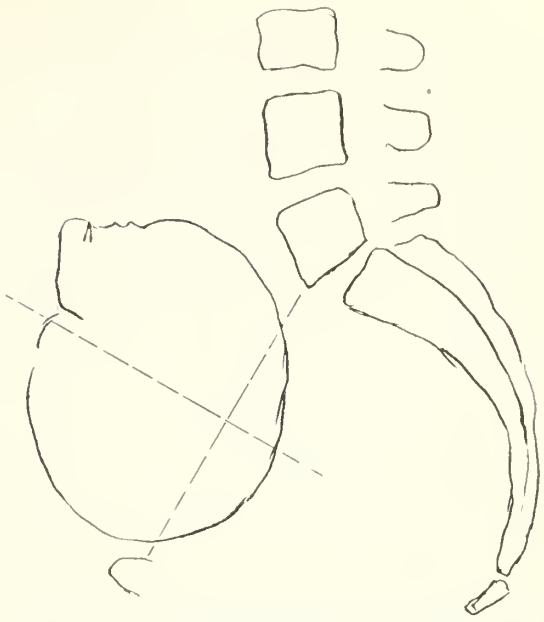


Fig. 8. L. O. A. before labor, but not engaged. Engages in L. O. P. 12 hours after labor sets in. Tracing from X-Ray Plate.

The cases which seem favorable are allowed to go into labor but are watched carefully. If there is much delay in the first stage I sometimes insert the Braun bag and do a version when the first stage is completed. The excessive angle makes no trouble for the after coming head. In some cases, in which the bag is not indicated, the head engages transversely and, if there is much delay, forceps are indicated.

The mechanism involves more difficulty than the primarily posterior positions. Even in the most favorable cases there are factors which cause apprehension. There is the long first stage due partly to the high position of the head; the tedious and difficult engagement; and the long arcs of rotation, first back for 90 degrees and then forward 135 degrees.

Gillespie describes the extensive moulding and even secondary moulding which he noted in difficult cases due to disproportion. The short heavy woman in whom the excessive angle is so often found is also the type in which disproportion is common. The bones are heavy and abridgement of internal diameters is frequent, even with normal external measurements.

In these secondary positions a disproportion, even slight, I regard as an indication for Cesarean section. In a few instances, with very marked pelvic tilt, I have elected section even in the absence of disproportion.

I therefore advise careful bimanual examination of these potential secondary cases a month in advance of term, under general anesthesia. In this way I believe these dangerous secondary positions may be largely eliminated.

MELROSE BUILDING.

Ocular Symptoms of Brain Tumors

Wm. Evans Bruner, A.M., M.D., Sc. D., and F.A.C.S., Cleveland, Ohio

Papillitis is undoubtedly the most frequent of all the objective and headache of all the subjective symptoms of intracranial tumors, and of the ocular symptoms perimetry and a study of the ocular muscles are extremely important. Roentgenography has likewise become a most valuable adjunct in arriving at a diagnosis, especially as to the localization, but also as to the type of tumor. In more recent years the value of injecting the ventricles with air and then taking radiograms, has been recognized and must receive due consideration. Spinal puncture to determine the pressure and to study the character of the spinal fluid, may also be advisable, but this should be done with the realization that in certain tumors such a procedure is attended with great risk, and has sometimes even proved fatal. A detailed history of all the symptoms, in a chronological order of their appearance, and a careful evaluation of all the physical signs and symptoms, are among the most, if not in fact the most, important aids in helping us to determine the character and location of such growths.

Tumors in the region of the sella, whether within the sella or supra-sellar, belong in a class by themselves. They form an extremely interesting and important group, and their treatment is attended with brilliant post-operative and therapeutic results. The characteristic or typical field in tumors pressing upon the chiasm, is, of course, bitemporal hemianopsia. In other cases we will find total blindness of one eye and temporal hemianopsia of the other—cases where pressure, at first, has been exerted upon the one optic nerve exclusively and only with its growth has reached and pressed upon the decussating fibres to the other eye. I have seen one case with hemiachromatopsia instead of hemianopsia in the second eye,—the temporal blindness being only for colors and not for form. This may precede the complete hemianopsia. More rarely the field defect may first show as an homonomous hemianopsia and the typical bitemporal field develop later.

Dr. Harvey Cushing has reported a number of such cases, and I have seen and reported one such—a patient upon whom Dr. Cushing operated —a case of supra-sellar cyst of the craniopharyngeal pouch variety. It is not my intention, however, at this time to dwell at length upon this type of tumor.

One other group of intra-cranial lesions might also well be mentioned here—chronic cisternal arachnoiditis with bitemporal hemianopsia and primary optic atrophy, or in some cases normal nerves. Two articles upon this type have appeared in recent numbers of the Archives of Ophthalmology, one by a fellow member of this Section, Dr. Derrick Vail.

These writers are of the opinion that this condition is more common than has been usually supposed, and one of the writers holds that when an etiologic factor is present, it falls into one of two groups, an antecedent trauma or an antecedent infection. It fails to expand or destroy the sella and in this respect resembles a supra-sellar lesion. Another point of difference is the rapidity with which vision may be lost.

Dr. de Schweinitz speaks of seeing several cases of retrobulbar neuritis ipsolateral to a tumor or abscess of the frontal lobe with papillitis in the opposite eye, and Foster Kennedy, in 1911, called attention to the syndrome of homolateral optic atrophy, contralateral papilledema and anosmia, or disturbance or absence of the sense of smell, and stated that it is usually, but not invariably, situated in the meridian line and has been designated as a meningioma of the olfactory groove. Cushing discussed these tumors in the Macewen Lecture of 1927, and recently Davis reported such a case in detail in the Archives of Ophthalmology for August, 1931, with recovery following operation.

A change in personality is observed, it is stated, in a large percentage of persons with tumors of the frontal lobe, whether the lesion is basal, subcortical or cortical. The ocular symptoms may not be so characteristic if the lesion is not basal.

Tumors posterior to the chiasm present a picture of homonomous hemianopsia, partial or complete. If this tumor is located posterior to the chiasm but anterior to the basal ganglia, we may obtain the so-called Wernicke's symptom, by which we mean that a ray of light when thrown upon the blind side of the retina, will produce no pupillary reflex, but will produce it when thrown upon the seeing side. This is due to the fact that the stimulus can not pass to the basal optic thalamus and thence to the oculo-motor nucleus. I have in my years of practice, as I recall, seen only one such typical case and that was many years ago. The subsequent history of that particular case was interesting because of the fact that the patient passed from my observation, was admitted to another hospital, was trephined over the motor area with resulting hemiplegia, and the autopsy showed a basal tumor as we had suspected.

If, however, the tumor is posterior to the point where the fibres are given off to the basal ganglia, the circuit to the oculomotor nucleus and the pupils will not be interfered with, and the light impulse, even though it can not be carried to the

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receptive centers in the cortex, will reach the pupillary centers and cause reaction of the pupils, so that the pupil will react whether light is thrown upon the blind or seeing portion of the retina. Such an homonomous hemianopsia, partial or complete, may accordingly be caused by a lesion anywhere posterior to the basal ganglia, along the optic tract, in the optic radiations, or in the subcortical or cortical area of the occipital lobe. In a differential diagnosis other neurological symptoms must aid us, if we hope to arrive at a more definite localization.

Disturbances of vision may vary greatly in papillitis. We may in some cases have early loss of vision, while in others vision may remain good despite a marked swelling of the nerve-heads. Transient obscurations of vision may be seen in some of these cases in the early stages, obscurations which may last but a few seconds though they may recur even many times a day.

Non-hemianopic defects including irregular contraction of the fields, enlargement of the blind spot, or relative and later absolute central scotoma, are not so important as the hemianopic changes above descibed, nor so helpful in aiding localization.

It is not my purpose, however, to review and evaluate these symptoms in more detail. I think it might be worth while instead, in the short time at my disposal, to review several cases which presented few or no localizing symptoms, but which showed the results of decompression operation where no tumor could be localized before and none were found at the time of operation, results most gratifying, even in several of them where the early prognosis appeared most unfavorable.

Before citing these cases I do, however, wish to speak of one other point in regard to localization of the side of the brain in which the tumor is located, as indicated by the papillitis. If the papillitis is unilateral, or is more pronounced in one eye than the other, the tumor is more commonly on the side of the unilateral papillitis, or the side in which the swelling is more pronounced, but there are so many exceptions to this rule that it can not be depended upon. Then, too, we should remember that though the presence of a papillitis in a suspected case of brain tumor is of marked positive value, the absence of papillitis is not of equal negative value; and one examination is not sufficient,—a patient who may show nothing upon ophthalmoscopic examination today, may a short time later show very definite evidence of increased intracranial pressure. I have had several such experiences in my own practice. This should make us very charitable and careful in expressing an opinion where we find evidence of increased pressure in a patient whom a confrere examined some time previously and pronounced the nerves normal.

A caution might well be added here, especially to those not specializing in ophthalmology.

Druzen neuritis might readily be given a wrong significance and interpretation by those not familiar with this condition. I recall one such case seen in a young girl of 17, in 1897; ten years later the left eye developed a retinal hemorrhage with a field defect on the nasal side due to it. This hemorrhage disappeared within a week. When last seen, in March, 1931, thirty-four years after the first examination and twenty-four years after she had had the hemorrhage, vision was 6/5 in each eye, the nerves presented the same appearance, the edges were hazy, the nerves apparently slightly elevated, druzen spots in each nerve, larger and more numerous in the left, the left nerve decidedly paler and a hazy area in the nasal portion of the field of this eye; otherwise the patient presented no untoward symptoms and was simply in need of a change in glasses.

I have also seen retained nerve sheath or medullated nerve fibres mistaken for neuritis, and especially recall one patient with suspected brain lesion who, in addition to the typical picture of marked medullated nerve fibres, also had retinal hemorrhages. These were due to hypertension and nephritis and, of course, operation was contra-indicated.

Pseudo-neuritis might also be readily mistaken for a papillitis of increased intra-cranial pressure. I have in my possession a lantern slide of a patient's fundus, sent me by an oculist of another city. This patient was under the care of a well known neurologic surgeon, who contemplated operation because of severe headaches and other symptoms suggesting an intra-cranial growth. The oculist found a very high degree of hyperopia with astigmatism and corrected the error of refraction with glasses, whereupon all the symptoms disappeared. This apparent pseudo-neuritis will often be readily explained and will disappear if we make a careful ophthalmoscopic examination of the patient through the correcting lenses. In suspected swelling of the optic nerves we must not forget that it is not sufficient to measure the top of the nerves when this is seen with a strong plus lens, but must measure the difference between the nerve and the balance of the fundus to determine whether there is in reality actual swelling present, or whether the entire fundus merely shows high hyperopia.

We must also never lose track of the fact that many other conditions besides brain tumors may produce a unilateral or bilateral papillitis, and these possibilities must as far as possible be excluded in attempting to arrive at a diagnosis in suspected cases of this kind; a careful study of the patient's history and all other symptoms and a complete physical and neurological examination should be made.

I recall a patient with suspected brain tumor, whom I was called upon to see many years ago by a surgeon before operation. From the condition of the retinal vessels I made a diagnosis of arteriosclerosis of the cerebral vessels and probable cerebral hemorrhage, rather than an intracranial growth. An operation, however, was nevertheless performed, but no tumor was found, —only a marked sclerosis of the cerebral vessels.

I have not mentioned another important symptom, or group of symptoms, namely, paralysis of one or more of the ocular muscles,—a condition which, when present, must receive careful consideration.

With this brief survey of the ocular symptoms of brain tumor, I should like to give in some detail the history of several patients upon whom, in the absence of all localizing symptoms, a decompression operation was performed, with the primary object of saving the vision and with the intention, if symptoms later warranted or demanded it, of doing a second operation.

CASE REPORTS

Miss O.—Age 17—consulted us November 11, 1922, because of recent frontal headaches, apparently worse after use of the eyes. Vision O.D. 6/6, O.S. 6/5 partly. 0.50 pp. 9 c.m. in each, esophoria 2°, right hyperphoria ½. Fundus—nothing pathologic found, low hyperopia.

December 20, 1922, about five weeks later, she came again, complaining of the headaches being more marked—for a week she had been having diplopia at long distance but not near at hand and some blur before the right eye. The previous evening her parents thought she looked "crossed-eyed." Vision O.D. 6/6?, with +.50 cylinder axis 90, 6/5-2; O.S. 6/5, esophoria 16-18. With red glass diplopia fused by 16° base out, images separate to her left, indicating paresis of left external rectus. Pupils equal, field normal. Ophthalmoscopic examination: O.D. very hyperaemic, edges hidden, inner half swollen 1D, one or two retinal hemorrhages; O.S. nerve more swollen, 2D, numerous retinal hemorrhages.

Dr. John Phillips could find nothing in his general examination, but she gave the history of having been ill for several days early in the month with a probable influenza, of which there had been an epidemic of a severe form at the farm, and some of the help had been sick. The diplopia gradually decreased and disappeared, and her general symptoms improved, but the swelling of the optic nerves increased even more in the right eye than in the left and the hemorrhages became more numerous in the right eye. The paralysis would vary and occasionally she had nystagmus to her right.

I referred her to Dr. Harvey Cushing, who felt that she undoubtedly had an intra-cranial tumor and suspected it to be a cerebellar growth. After keeping her under observation for a time, he did a decompression, in January, 1923, and found the right hemisphere a little larger than the left, but nothing on the surface, and thought she must have a deep seated glioma. The diplopia disappeared at once and the papilledema began to subside.

March 20, 1923,—vision O.D. 6/5 partly, O.S. 6/5; accommodation normal in each; with Maddox rod esophoria 3, no hyperphoria, no diplopia with red glass, and all ocular movements normal. Ophthalmoscopic examination showed mere haziness of inner edges of each nerve, the nasal half slightly more prominent than the temporal, in fact the nerves looked practically normal. Fields were normal.

I have seen her once since, on January 20, 1926 (three years later), when she came in for a check-up. She is perfectly well and having no symptoms whatever. Vision O.D. 6/5, left 6/5. 0.50 pp. 1 c.m. in each. Eyes in good position under cover and all movements good. Form fields normal. Ophthalmoscopic examination—absolutely healthy and normal looking fundi, nothing found in either eye which in any way is the least suggestive of the old trouble, nerves perfectly healthy, normal color, normal vessels.

E. C.—Age 7—had been examined by us, in December, 1920, because of some discomfort in reading. She was found to have a perfectly healthy pair of eyes, with only a very small error of refraction and slight insufficiency of the internal recti muscles (exophoria 3). I did not see her again until February 19, 1925—age 11, when she returned with the history that she had been having some headaches, worse after use of the eyes, and was being treated for a slight cystitis recently. She had been having some nausea and dizziness, especially marked when she first arises in the morning.

Examination showed vision 6/6 in each eye, accommodation normal, exophoria 6 but variable in amount, with poor forced convergence. Ophthalmoscopic examination—nerves very hyperaemic with all edges hidden and swollen 1-2D; O.S. same appearance but nerves slightly less swollen. She recently had had the "flu." Nose, throat and sinuses were all negative.

March 8—patient has much dizziness, falis frequently, but has always been awkward, nausea but no vomiting.

Examination by her general physician was negative. Dr. Locke, a neurological surgeon, reports that *X*-ray of the skull indicates increased intra-cranial pressure, and this with her other symptoms made him very suspicious of an intracranial growth. Moderate neurological symptoms continued, vision remained 6/5 in each eye, and nerves about the same.

Upon my advice she went to see Dr. Harvey Cushing, who operated July 28, 1925, and reported as follows under date of August 14: "We could not be sure of the situatiton of the lesion, though I have a suspicion that it may in time prove to be cerebellar. The symptoms were not sufficiently marked to justify such an elaborate procedure as a cerebellar exploration. Consequently, merely in the hope of relieving the choked discs, I made a routine subtemporal decompression, and am glad to say that her papilledema was rapidly subsiding when she left here."

Her general condition gradually improved though she continued to have frequent severe headaches and occasional dizziness, and a moderate edema of the optic nerves continued. Glasses, which I gave her, had little effect upon the headaches.

I saw her last in December, 1931, six and one-half years after the operation, during her Christmas vacation. She had been very well except for these frequent headaches. Vision was 6/5 in each eye, accommodation normal, exophoria 2, with convergence as usual, pupils equal, prompt to light, fields normal. Ophthalmoscopic examination reveals the same edematous appearance of the nerves,—the top of the nerve showing about

1-1/2D of swelling in the right and 2D in the left, good color, no hemorrhages and no exudate.

L. T.—Age 44—consulted us June 5, 1926, with the history that he had had good eyes until two weeks ago. He first noticed sudden failure of vision in the left eye, which became totally blind in three days. Six days later vision of the right eye began to fail, and in three days it also was blind.

His general health had been excellent and all examinations were negative.

Examination showed both eyes totally blind,—pupils were widely and evenly dilated and did not respond to light. Ophthalmoscopic examination: right eye—nerve very hyperaemic, edges hidden, especially the inner-optic neuritis with beginning edema though as yet no definite swelling, certainly not more than ½-1D, the veins much dilated and tortuous, no hemorrhages, no exudate; left eye—more marked edema and definite papillitis, edges entirely hidden, veins much dilated and tortuous, one rather large flame-shaped hemorrhage.

The patient was referred to Dr. Elliott Cutler, who, two days later, under local anesthesia, made a large flap in the left side of the skull but found no indication of increased pressure; he had a good view at the base but could see nothing pathologic. Two days later patient had a convulsion and some disturbance of respiration. On the third day, as patient was semi-comatose, very restless, and optic nerves looked very hazy, the doctor made a second operation, opening the flap, and removed blood clots. The patient had some additional convulsions and for a time seemed worse, and then began gradually to improve. On the 14th, seven days later, patient could count fingers with the right eye and fields showed roughly a temporal hemianopsia, with left eye totally blind,—pointing to a lesion about the chiasm. The following day he could count fingers on nasal side of left eye, and his mental condition was steadily improving. He left the hospital on the 23d, sixteen days after operation; the edema of the optic nerves had practically disappeared, he could count fingers at 18 inches with each eye, and a rough test showed the form fields practically normal.

He continued to improve, and when last seen at the office, November 1, 1926, five months after operation, vision was 5/7.5 in each eye, and with a sphere he could read 0.50 print fairly well. The form fields were perfectly normal. Ophthalmoscopic examination showed nerves gray, arteries narrow, veins full,—in other words, some optic atrophy.

A letter from his wife, May 17, 1927, stated that his vision was about the same and he was feeling much better—certainly a brilliant result in what appeared a hopeless condition.

Mrs. T. M.—Age 29—referred to us by her family physician April 28, 1931, with the history that two weeks before she had had a sudden onset of severe headaches. Vision began rapidly to fail in the right eye eight days ago and two days later in the left. There was no nausea, vomiting nor fever.

Examination showed vision in right eye poor light perception, left eye blind.

Ophthalmoscopic examination: right eye—edema of optic nerve and some papillitis, more marked in the nasal side, where the edges were more completely hidden, veins dilated and tortuous, no hemorrhages nor exudate, top of nerve about 3D above fundus; left eye—similar appearance but whole nerve more involved and swollen, no hemorrhages.

Her friends were told of her very serious condition, and she was advised to go at once to the hospital. Dr. Cutler reported that nothing whatever could be found in a general or neurological examination. Two days later the swelling of the optic nerves appeared rather more pronounced,—the left showing about 1D of swelling more than the right; on the same day he did a decompression on the right side.

Three days later patient looked much better, could count fingers with right eye and see light with the left. She left the hospital on the 11th, when she could count fingers at 2-3m. with the right eye and see hand movements with the left. Form field in the right eye was normal, in the left normal down and out, but upper inner sector was gone, including fixation. Edema of optic nerves was decidedly less.

May 25, at the office, vision right eye 6/15, left eye 6/60, form field normal in each eye, no scotoma, but marked contraction of color fields. Ophthalmoscopic examination showed edema gone from both eyes with both nerves pale, arteries slightly contracted.

September 8, 1931, patient drove her own car from Sandusky to Cleveland. Vision right eye 6/6-2 with effort, left eye 6/6-1. She could read 0.50 print with each eye. Form fields normal and fairly good color fields, though not tested on perimeter. Ophthalmoscope—not the slightest edema in either eye but nerves pale, arteries only slightly narrowed.

We last saw her November 23, 1931. Vision right eye 6/6-3, left eye 6/6.

This case also demonstrated the value of a decompression operation, in the absence of all localizing symptoms, in a patient where the prognosis certainly, as regards vision at least, was most unfavorable.

I might report many other cases of intracranial tumors of various types. All of them, of course, did not show such a gratifying outcome, but these are given as representing a type of patients who presented no localizing symptoms, were operated upon by decompression as a palliative measure, and obtained an apparent cure.

GUARDIAN BUILDING.

DISCUSSION

D. T. VAIL, JR., M.D., Cincinnati, Ohio: In discussing the "Ocular Manifestations of Head Conditions" from the opthalmological viewpoint, the essayist has done well to limit his paper practically to intracranial growths. To cover the whole field adequately in this short time would be impossible since books have been written on the assigned topic alone. Brain tumors, ophthalmologically speaking, form the easiest and at the same time the most difficult group for diagnosis, with which we have to deal. The recognition of choked disc and perimetric field defects, as well as the proper diagnosis of ocular muscle defects should present no difficulty as a rule. The interpretation of these findings, however, calls for a high degree of diagnostic acumen based upon all the available data, such as a most careful clinical history, neurological examination, spinal pressure readings and roentgen ray pictures. All of these points the essayist has adequately presented and I but wish to emphasize them in passing. There are a few observations which might be added. One is, that often a patient with a bitemporal hemianopsia may only read the letters (on the test card at twenty feet) on the left side with his right eye and the right side with his left eye. Frequently the vision with each eye may be three or four lines less or worse than with both eyes together.

Another personal observation, contrary to the essayist's experience, is that temporal blindness for color and not for form generally precedes the bitemporal hemianopsia, and is the last to return to normal. I recall especially a case where the right field showed a large temporal defect for white and colors, the left for colors only, the peripheral form field being entirely normal. At operation a large pituitary cyst was found.

Another case showed a bilateral relative central scotoma and a diagnosis of toxic amblyopia was made. Two months later there had developed a bitemporal hemianopsia for colors only. *X*-ray examination showed an increased sella turcica and erosion of the posterior clinoids.

X-ray pictures of the optic canal have also been found useful in diagnosis of lesions involving the chiasm. This is especially so in neurofibroma of the chiasm when the growth invades one or both orbits through the optic canals.

Dr. Bruner has mentioned chronic cisternal arachnoiditis with primary optic atrophy. It has been my good fortune to have collaborated with Dr. George Heuer in a study of two of these cases, which have been cured by surgery. Since that time I have seen one patient who had, I am sure, the same condition. A young woman rapidly lost her vision in the left eye, eight days later the right vision failed. Except for a moderate bilateral papilledema, all findings were negative. This includes spinal pressure readings, spinal Wassermann, sinus examination, *X*-rays of skull, and neurological examination which ruled out encephalitis and multiple sclerosis. She was given a large series of intravenous sodium iodide treatments with return of her vision to normal (20/20) each eye. The temporal color fields were the last to be restored and for a long time there still existed a small relative central scotoma. Both discs at the present time, one year after the onset, show a characteristic primary optic atrophy.

Foster Kennedy's syndrome of frontal lobe tumors, to which Dr. Bruner has drawn your attention, should always be remembered in the differential diagnosis of bilateral central scotoma. A heavy pipe smoker, 58 years old, was seen in October, 1928. He had bilateral relative central scotoma and a diagnosis of tobacco amblyopia was made. His vision at that time was right 20/40—, left 20/70—. He stopped smoking and two weeks later his vision was 20/30 each eye. I didn't see him again until exactly two years later when both discs showed about four diopters of swelling, a little more in the left. Dr. H. D. McIntyre, after a careful neurological examination, diagnosed a left frontal lobe tumor. The patient died December 3, 1930, following a brain operation, which revealed a bilateral frontal lobe tumor at the base and a left frontal lobe tumor.

Another patient who has bilateral relative central scotoma, whose vision improved somewhat after he stopped smoking, is being carefully observed at present because of his euphoria, facetiousness and the presence of a slightly increased spinal fluid pressure.

A complete chapter could be written around ocular motor palsies and their intracranial significance. Dr. Bruner has already touched upon this factor very ably, but I should like to recall to your minds that an intracranial aneurysm should be thought of in the differential diagnosis; as well as the more common tumors, vascular disease, multiple sclerosis and encephalitis; all of which may show muscle changes as well as optic nerve involvement, corneal anesthesia, and field defects.

Dr. Bruner's first case suggests encephalitis following influenza, and his last two cases might have been chronic cisternal arachnoiditis ones.

In conclusion I should like to repeat and reemphasize the essayist's remarks on a careful history, careful fields of vision for white and colors, frequent ophthalmoscopic observations, spinal pressure readings, muscle studies, neurologic examination and *X*-ray photographs including the optic canal as well as the sella turcica, in short, a balancing and weighing of all evidence at hand, in order to arrive at a correct diagnosis and localization.

NEW BOOKS

New and Nonofficial Remedies, 1932, containing descriptions of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on Jan. 1, 1932. Cloth. Price, postpaid, $1.50. Pp. 492. lvi. Chicago: American Medical Association.

The recognition of a preparation for inclusion in this book singles it out from the host of new products of the pharmaceutical manufacturers as being a worthwhile addition to the existing armamentarium of the practicing physician. To be thus distinguished it must be shown, under the impartial scrutiny of the carefully chosen group which is the Council on Pharmacy and Chemistry, that it has acceptable evidence of therapeutic usefulness and that it is marketed in accordance with the honesty and straightforwardness envisaged by the excellent Rules which have been the outgrowth of the Council's quarter century experience in appraising the merits of new drugs.

In accordance with its custom of keeping the annual editions of New and Nonofficial Remedies in the forefront of current medical thought, the Council offers in this volume the newly revised articles: Barbital and Barbital Compounds; Fibrin Ferments and Thromboplastic Substances; Liver and Stomach Preparations; Mercury and Mercury Compounds; and Ovary. Perhaps the most noteworthy new preparations admitted are: nupercaine-Ciba, a local anesthetic; pentobarbital sodium, a barbituric acid derivative; and iopax, a new preparation for roentgenologic use. All of the ovary preparations formerly described are omitted and none of the new standardized preparations are described, although the names Theelin and Theelol are recognized in the revised general article. Another change of importance is the classification of articles formerly listed as "Exempted" under the heading "Accepted but Not Described." There is the usual excellent index and the augmented Index to Proprietaries Not Included in N. N. R.

Community Health Organization, edited by Professor Ira V. Hiscock, Yale University, for the Committee on Administrative Practice of the American Public Health Association and published by the Commonwealth Fund; an administrative handbook for the public health officer and his staff and based on studies of more than 200 city health departments. Price $2.50.

A Discussion of Industrial Medicine

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TWENTY years ago the literature pertaining to industrial medicine in the United States was confined largely to diseases of occupation. Occasional articles appeared on the subject of occupational disease laws, treating these matters as labor legislation, rather than legislation affecting medical practice. With descriptions of lead and phosphorous poisoning are found essays on traumatic surgery but the latter considered the subject not so much as industrial injuries as surgical incidents.

Five years later the trend of the literature had set definitely toward the problems of medicine in industry. This was so for the very good reason that industry was establishing medical departments to care for employees suffering from accidents and occupational disease. For in that five-year period several states had enacted workmen's compensation laws, covering accidents and sometimes the diseases of occupation. The employer and the insurance company came to the conclusion that the physician would prove an economic asset if placed so that he could select only physically fit applicants for work and could care for injuries and disease incurred in the course of employment.

Establishment of these industrial medical departments led to a deep interest in this type of work by physicians, and those interested in the problems of labor and social medicine. As always happens when enough individuals become interested in definite lines of endeavor, national, state and local associations were formed, the membership for the greater part being composed of physicians and surgeons engaged in industrial work, on a full or part time basis.

Emphasis was laid upon preventive as well as curative medicine, and sections on preventive medicine of established organizations were broadened to include industrial medicine as being related to public health. Magazines and sections of magazines limited to articles dealing with the subject, came into being and still exist. The World War stimulated a tremendous growth of this type of work. Industrial medicine was heralded as a new specialty.

Every specialty must have specialists to practice it or there would be no such specialty. So those of us in this work became industrial physicians and discussed its medical, economic and social problems before the associations and sections interested, and published these discussions in the magazines and sections of magazines devoted to the cause. Lay executives seldom expressed their view in these media and we were left to tell the world and each other what industry needed in the way of medical service, and how it paid dividends by reducing lost time on account of sickness and accidents, and by increasing the efficiency of the worker. It was necessary to be somewhat imaginative at times in order to do this well, and to assign intangible values to intangible results. The papers read and discussed at these meetings, with occasional direct contributions, became the source of the greater part of the literature.

To give you an idea of the way some of us thought about this work in its earlier days, let me quote part of the report of a committee appointed in 1915 by the Section on Preventive Medicine and Public Health, of the American Medical Association. It was the duty of this committee to outline the immediate problems of industrial hygiene and the relation of the medical profession to their solution. The report was presented at the Detroit meeting of the Association in June, 1916, and among other things said: "In studying the situation, one fact stands out prominently, and that is that the great mass of workmen has been denied the opportunity of enjoying, even in a reasonable degree, healthful living and working conditions. This situation has furnished a common ground on which all parties interested could meet.

As a result the past decade has witnessed the development of industrial hygiene to a considerable degree, thus paving the way for further mutual adjustments, and compromises. It is obvious that no narrow conception of the field of industrial hygiene can be regarded as common ground on which capital and labor may meet or be expected to establish the modern counterpart of the former relation of master and man.

It is the broader conception of the importance of the health of the worker which has introduced the physician into industrial management. As Dean Marquis says, "It is the duty of the factory doctor to promote understanding between employer and employee, to take drudgery out of labor and to maintain interest in the individual; in other words, to put a soul into his corporation. The right man in this capacity will stamp out much bitterness and readjust human relations! . . . co-operation with others in like fields is necessary and research must be undertaken in order to provide solutions of problems of national interest. Two of these are the prevention of alcoholism and the development of a system of mutual helpfulness by means of insurance."[1]

In that day it will be noted that the industrial physician was to assume the role of interpreter between so-called "Capital and Labor", stamp out

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bitterness and readjust human relations in addition to putting a soul into the corporation; and industrial medicine was to approach national problems as well, seeking in its own way to solve problems such as the one which has been cared for since by the Eighteenth Amendment, more or less successfully according to one's point of view.

The qualifications of the industrial physician was a favorite topic. They were many and varied and the descriptions of these attributes are little different today than in 1921 when Clark stated that . . . "he must be a hospital graduate with surgical experience and a good general internist; have organizing and executive ability and a general knowledge of public health problems; be familiar with methods of prevention of disease and accidents among the entire group of the employees and be prepared to give constant supervision to the health of the employees, including working conditions, the hazards of each occupation, the question of hours and wages and adequate medical and surgical care of the sick and injured; be trained in the selection of occupations according to the physical qualifications of the individual and the restoration of the disabled to physical usefulness."[2]

That was a period of idealism and many of us thought that the remedy for many industrial evils lay, as indicated, in our sphere of endeavor. But the industrial physician is not the one to put a soul into a corporation nor is he the one to interpret the problems of capital and labor. Those attributes must exist in the personalities of management, if they are to be effective at all, for with management lies the responsibility of formulating and carrying out policies leading to their solution.

I cannot agree with Clark and later writers that the physician in industry must be endowed with more than usual gifts. What is there in the training of a physician that fits him to be all these things? How can he be an executive, organizer, surgeon, internist, health officer, epidemiologist, safety engineer, health supervisor, efficiency engineer and employment manager? The answer is that he can not. As an ordinarily intelligent person interested in his environment, he can advise on some of these subjects but his vocation is the practice of medicine.

It takes a peculiar type of mind to be content to work under the conditions imposed by industry, and if one has that type of mind and a decent professional training, one can succeed. The most essential qualification is to be able to care for those individuals who become his charges with as much ability and interest as would be shown if they were his patients in private practice.

It has been stated that professional care given to groups is impersonal and that the relation is not that of physician and patient. If this be true, it is the fault of the physician, for no patient encountered in industrial work presents exactly the same problem and each must be treated individually if the best results are to be secured. Standardization of treatment cannot be obtained except on basic principles, and if one loses interest or lacks stimulation it is because he is the type of physician who would be in the same predicament were he practicing privately.

Physical examinations were not established in order to help the employee. They were established because workmen's compensation laws put a premium upon new injuries causing an exacerbation of existing injuries and disease, and the examination was for the purpose of limiting this liability by selection of the physically fit. It is said that to be of value the examination must react to the benefit of employee, employer, and community. To accomplish the former the physician was to inculcate the rudiments of health education during the examination, but I am definitely of the opinion that the method is not successful. Very few of us would have this and that done because we were told by a strange physician that our health might suffer if we didn't. And many of us would worry after a discussion of the future possibilities of increased blood pressure, a trace of albumen, dulness over an apex, or a murmur in the heart. Industry is not equipped to make a physical examination that will determine the degree of physical fitness of an applicant for any given work. It cannot afford the time and money necessary for it, nor is it necessary to have that type of examination. I have heard men advocate making *X*-rays of the spine of every applicant for employment in order to detect arthritis. Others have held that Wassermann examinations were necessary and still others that *X*-rays of the lungs should be made. These things are no more necessary than functional kidney tests, electrocardiagrams, blood chemistry, and a gastro-intestinal series.

The physical examination should be used to secure the average person of any given age who is able to do the work for which he is hired. It should not be used to protect insurance plans. It should be given with the idea that it is a crime to deny any man the right to earn his living unless there is an exceptional reason for that action.

When it comes to instruction in the care of health during an examination such as it is possible to give applicants for work, it seems to me that more harm can be done than good. Men have to work and if they are beginning to break at the age when we see them, I cannot feel that we are doing a great deal toward helping them if we tell them that blood pressure is beginning to rise, arteries are beginning to harden, hearts are beginning to wear out, and kidneys are beginning to deteriorate.

Periodic examinations in industry are not of as much value as we have held them to be and this is for the reason that the workman, whether he be the president of the company or a sweeper in the

ranks, can seldom drop his work to secure the greatest of all remedies—rest. Few have the money to carry out remedial measures; and clothes, shelter and food for family and self come first. Too often worry is the sole result of misunderstood instruction.

I am not insensible to the fact that removal of obvious handicaps is of the greatest benefit to the individual, but I believe it best for the physician in industry not to worry too much about this, but to let the individual's own physician carry the responsibility. With the increased turn-over of labor in good times and with the forced separations in times of economic stress, periodic examinations of the whole force mean a great loss to the industry without compensating gain, tangible or intangible. If everyone were to keep their positions throughout the years with only enough replacements to care for those who leave because of death, old age, or voluntary resignation, these examinations might be of value. They are definitely for the physician in private practice.

The argument that correction of defects disclosed by periodic examinations repays industry in increased efficiency for the individual, does not hold true. It would if we could stop the processes that are due to advancing age but this is seldom possible. The statement that industry repairs its machines when necessary and so should repair the operator of the machine, is not sound. Worn out vital organs cannot be replaced with new. Changing a man from the job he knows to one with which he is not familiar in order to protect his health may do far more damage than disease, particularly when this action involves loss of income. Light work is scarce in factories. Industry scraps machines mechanical and human when their usefulness is at an end. Some do it humanely in the case of humans, and some do not, but industry does not operate with reclaimed men. It requires the strength of youth.

Dispensaries should be so maintained and attended that the physicians in charge can care for the majority of cases. It is a mistake to leave the diagnosis and treatment of any injury or disease to a nurse or first aid man. The nurse rarely aspires to this responsibility, and when she does, she is practicing medicine without a license.

It has been said many times that the physician in industry is better equipped to observe employees than the physician in private practice. Because he has laboratory aids and the time to adequately examine employees coming to the medical department, it has been proposed by some that the industrial physician should co-operate with the family physician by furnishing these physical examinations and consultations, sending the results to the latter in order that he may carry out the treatment. This is not a function of industry and implies lack of ability on the part of the private physician. The equipment of the medical department should be used for the diagnosis of injury or occupational disease, and not often for the determination of the abnormal in those who wish medical attention not incident to employment.

Industry often added medical services for employees, of which dentistry is a good example. There is no more reason for this, except in special cases, than there is for furnishing medical care to employees and their families. I believe it to be much simpler to maintain a loan fund and to underwrite the medical, dental, and hospital expenses of those who qualify for this aid. Repayment in equal installments over a year's time provides a revolving fund that proves unusually useful. This allows the employees free choice of medical facilities and the aid of a physician or dentist of his own choosing.

Nor is it wise to make *X*-rays for employees as many of us have done, freely and without reserve. Few of us have the ability to accurately interpret *X*-rays and if interpretations are not made for the physician whose patient the employee is, the physician may be led into error by his own lack of ability to read the films. This work lies in the province of the roentgenologist.

It is the duty of all of us in this type of work to see that the relations between patient and personal physicians are not disturbed. There are occasions when one seems justified in using procedures which may appear detrimental to the physician in private practice but when this occurs, a frank discussion of the incident will usually clear the matter.

In my opinion the industrial physician has discharged his duty to the employer when he furnishes adequate surgical and medical care to those employees who are injured in the course of their employment or who suffer from occupational disease. That is a narrow conception but it is true. We are in industry only because we save money for it, not for philanthropic reasons nor as a welfare agency; and if we confine our activities to the practice of medicine, we have gone a long way toward securing what both the employer and employee desire.

Our obligation to the employee is fulfilled when the medical service provided for him in case of injury or occupational disease is adequate and unbiased reports are made. The duty of the industrial physician to the community is no more nor less than that of any physician in private practice, or citizen interested in its affairs. If he cooperates with the established departments of health a large part of his obligation is discharged.

Industry has an obligation to its physician. It owes him a decent place to work and adequate equipment. He should be responsible to an officer of the company from whom he may obtain definite advice in regard to its policies. His position should be such that he can commit himself or the

employer on any reasonable question involving medical matters.

It is unwise for physicians to engage in industrial practice on a full-time basis. Tenure of office is not secure even in the largest industries. Changes of management may mean changes in policy. These policies are not always such that the physician can carry on and maintain self-respect, and then there is but one thing to do. Part time connection with an industry is preferable. It means a definite economic protection for the physician but is not so advantageous to the industry. While the past two years have not caused any basic changes in the procedure in industrial medicine, today the economic situation has made it necessary to reduce both personnel and expense. One hears from time to time of doctors who have been with certain industries for years who are decidedly unhappy in their present environment.

In some industries operating directly under the State and not as self-insurers, physicians are guaranteed a certain sum for their services. Bills are made against the Industrial Commission in each case and if the amount received from the State is greater than the compensation of the doctor, the excess is returned to the company. This is bad practice. The physician should be entitled to all income received for medical care, for he takes the responsibility of life, death, or the return of function for each patient he cares for; and if there is any monetary reward, all of it should be his. The company cannot practice medicine.

I have said that articles dealing with occupational disease laws were treated as labor legislation and not as legislation affecting medical practice.

These articles were straws in the wind. The medical profession apparently was unaware that these were signs of approaching economic changes in medical practice and allowed compensation laws to be passed without much consideration of their future effect upon the profession.

From the physician's point of view it is wrong for industry to deprive its employees of the free choice of physician in case of accident. But regardless of the right or wrong of it, industry pays the largest part of the bill and will continue this course until a better plan is devised. That it can do this is due to the failure of organized medicine to prevent it at the time these enabling laws became effective.

Within the past few years society has urged the passage of occupational disease bills compensating any disease incurred in the course of employment or the exacerbation of existing disease by occupational exposure.

No one can deny the justice of such a law. But one can forecast that if it does not safeguard industry it will mean a greater growth of industrial work. The proof of diagnosis and whether the disease is due to occupation devolves upon the employer or state, rather than upon the employee, and it is more economical for industry to maintain a medical staff for the purpose of making a diagnosis than to pay men in private practice for it. It is only within the past few years that the medical profession has paid much attention to these laws, which vitally affect its practice. Ordinarily the bills are "agreed bills" when they reach the legislature; that is, they have been agreed upon and approved by the representatives of employer and employee—but seldom is the physician considered until after the agreement has been reached.

Workmen's compensation laws have created conditions under which definite economic advantages accrue to employer and employee, but not always to the physician in private practice. It is our duty as physicians in industry to see that the application of these laws causes as little disturbance as possible to the profession as a group. Hospitals, city, county and state institutions provide legitimate aid for those who are unable to procure it at a price. If these were wisely used industry will have little curative medicine to do other than that required by law. The education of laymen in prolonging enjoyable life will be better cared for by evolution through the years than by industries engaged in the manufacture of products in the hope of profit. Prevention of occupational disease and accidents does not require the intensive clinical training of a physician except infrequently, and the industrial hygienist can give better advice than one whose work is devoted to curative medicine and surgery.

It is my belief that industrial medicine should be considered, not as a specialty, but as adequate medical and surgical service applied to industry within legal limits. Its literature should be the literature of medicine and its problems should be presented in the regular sections of medicine and surgery for they affect the medical profession as a whole.

DISCUSSION

EMERY R. HAYHURST, M.D., Columbus, Ohio: The pendulum often swings too far and this is usually due to over-enthusiasm of those who are engaged in the issue so busily that they fail to note the world's view of relative importance, while oftentimes ambitious but inexperienced advocates add to the swing of the pendulum. After a period of twenty years it is well that someone with commensurate experience should attempt to view his own specialty from the standpoint of results, and should state his views frankly as Dr. Lowe has done upon industrial medicine. My own experience as an industrial hygienist is necessarily somewhat different from that of Dr. Lowe's and yet it involves the same problem—the health of the worker.

I do not think that the comprehensive statement of the duties which Dr. Lowe has quoted from one or two physicians in the field should be taken as the real criteria, but rather such a finding as the resolutions on preventive medicine in industry endorsed by the Health Division of the

National Safety Council at its meeting at the Hotel Stevens, Chicago, in September, 1927. (Transactions, General Sessions: 249). These resolutions are too long to repeat here, but in brief they stress that it is proper and right that industry, through its medical department, should take all steps possible along the lines of preventive medicine for their employes and their families; occupational accidents should receive proper surgical attention without limit under company supervision; diagnostic aid should be given the family physician by the corporation so far as possible in order to assist in returning the employe promptly to his work; but that it is not advisable, except in isolated places, for the family to receive medical attention itself at the expense of the corporation.

The extent to which the employer is compelled to go to protect himself from mishaps to the life and health of his employes is well illustrated by the case of Wallingford v. Industrial Commission of Ohio, decided January 20, 1932, by Judge Clevenger of the Common Pleas Court of Clinton County, where an experienced moulder of 40 years of age with a previous inkling of heart trouble dropped dead while carrying a laddle of metal when the indoor temperature of the foundry was 100°F. The case was decided in favor of the plaintiff and against the Commission and therefore the employer. The extent of illness among industrial employes, much of which is preventable if real preventive medicine and industrial hygiene are practiced, can likewise be readily seen from the various reports of Dean K. Brundage of the U. S. Public Health Service upon sickness among industrial employes.

Obviously no physician should be expected to be an engineer or a statistician or one of several other applications associated with employment, but the very fact that to be a successful industrial physician you must be an executive, an organizer, a health officer, an epidemiologist, and likewise distinctly socially-minded as well as competently trained in the principles of medicine and surgery shows in itself the necessity for training outside and above that which is usually obtained by the medical student in the average medical college. There is no doubt in my mind that the curriculum of most present medical colleges is old-fashioned and not in keeping with the relative importance of issues which the physician must meet when he enters the practice of medicine, but, over and above such changes as might be effected in the undergraduate curriculum, the proper basis for success in the field of industrial medicine lies in a formal course of post-graduate nature in which the twenty years of experience in America and the century of experience abroad is inculcated.

Undue refinements of course should be excluded, but where the safety of the public is concerned as in railroad work even some of these must be countenanced as a necessary part of industrial medicine. Certainly the correction of vision, hernia, fallen organs, upper respiratory conditions, etc., does increase the efficiency of the individual, whose organs take on a new capacity —a phenomenon without a fitting parallel in mechanical adaptations. To what extent the vigor of youth may supplant the experience of age is questionable at least in a great many callings and no doubt accounts, for example, for the fact that today the middle-aged person is so often retained or called back in the pinch of the depression.

I quite agree with Dr. Lowe at each point where he attacks curative medicine or dentistry as the proper field of industrial medicine, but I fail to see why a corporation might not hire the services of a roentgenologist for diagnostic work. Preventive medicine demands diagnosis the same as facts are needed for any rational procedures in hygiene. The spirit of modern medicine is prevention and the industrial physician who simply furnishes adequate surgical and medical care is out of tune or, Must we again go back to first principles and again decide whether prevention is better than cure?

The specialist in industrial medicine is not compelled to tie himself up with only one corporation but where he does, and he has ability, he will be able to negotiate other contacts, at least when industry is in any condition approaching the normal. I am sure that, at the present time, there are hosts of other specialists who are practically out of a job as well as the unfortunate industrial physician, who, by the way, is probably hanging on better than the average.

My own opinion is that the average practitioner in the various states is much better off under the present compensation laws than he was before they were instituted, whether or not he took any part in their creation. My own experience goes back to pre-compensation days when we recollect the chagrin we felt in being called to attend the industrial or public accident—for it was almost certain that we would have to present our bills to a soulless insurance casualty company which invariably cut them mercilessly or disallowed them entirely on some technical point.

Where 500 physicians engage in a special field of endeavor and most of them group themselves into one or two societies for mutual exchange and contact, it is my belief that such a field constitutes a specialty, over and above regular medicine and surgery.

Industrial medicine is the application of the principles of medicine, surgery and hygiene to the creative group of society. Its problems are different, its clients have little control of their environment, and its failure, so actuarians tell us, cost the country billions of dollars annually. It is therefore only logical to believe it should be intensified rather than curtailed, and enriched rather than restricted.

A. G. Cranch, M.D., Cleveland, Ohio: Dr. Lowe's paper in some ways has been a surprise to me, but, knowing him as I do and knowing something of the extent of his work in the field of industrial medicine, I feel that the purpose of his paper has been largely to make us think, and take stock once more of what really belongs in the field called industrial medicine. Ten or fifteen years ago, physicians in this field were subject to "expansive delusions". They aspired, perhaps, to too many activities outside the medical field, with the result that there has been a reaction. but this should not reach the stage which might be called "melancholic neurasthenia".

Perhaps we should make a distinction between, on the one hand, the good physician and surgeon working largely in the general field but who may serve some industries in the care of their industrial cases, and, on the other hand, the physician whose major interest is the application of medicine and surgery to industrial needs. In the first instance, I would not call this man an industrial physician, and his function as a physician is fulfilled both with reference to the industry and the patient when he has rendered adequate and intelligent care to the injury received or the disease contracted in industry. In the second instance, I believe the physician whose major interest is industrial medicine and surgery may rightfully be

called a specialist. He is not a specialist in the sense of the oculist or the dermatologist who deals exclusively with certain parts of the body; but he is a specialist in much the same sense as the pediatrist who is simply applying good medicine and surgery to a group of patients affected by special conditions. In the case of the pediatrist, his special field is determined essentially by the age of the patient. In the case of the industrial physician, it is determined by hazards of a more special type than those surrounding the population at large.

The industrial physician as a specialist must not only be a good physician and surgeon, but must also be enough of an industrial hygienist to engage in the preventive work required by industry. Industry needs this preventive work fully as much as the curative, and this field offers special opportunities for efficient practice of preventive medicine. I do not believe that the treatment of conditions arising out of other than industrial causes should be included in the practice of industrial medicine. It would hardly seem the function of industry to maintain elaborate diagnostic facilities in the way of *X*-ray and laboratories primarily as an aid to the treatment of general conditions. Such equipment is warranted only in so far as it is required for diagnostic work in connection with injuries and occupational diseases, or to determine preventive measures for which the company is responsible.

Regarding physical examinations in industry, no matter why they were established originally, I still believe that they can and do benefit employees, and are a most important aid in preventive work. They benefit not so much through advice and instruction given at the time of examination as through follow up based on findings at the time of examination. A man's physical handicaps are not only the result of advancing years but often due to conditions which can more readily be remedied. To be sure it is not the responsibility of the industrial physician to carry out the indicated treatment for the removal of these handicaps, but he can and should point out to the man the value of such treatment, and refer him back to his family physician, if he has one. As for periodical physical examinations, these, when done on a wholesale basis, may not yield results which would warrant an industry in carrying out such a program. Nevertheless, a program of selective re-examinations among older employees and those known to have progressive conditions may well be warranted.

Relative to the duty of the industrial physician to the employer, the employee and the community. This duty is only partially fulfilled through the adequate care of the injuries and diseases arising out of employment. To the employer, the physician has a duty in devising methods of prevention for occupational diseases and the elimination of conditions within the industry which may be detrimental to health. To the employee, I feel that there is a duty in addition to adequate treatment for industrial conditions, to point out to him any other conditions noted where treatment may be indicated, and to help him, as far as possible, in reaching the proper agency for the treatment of such conditions. To the community, the industrial physician has a larger duty, I believe, than the physician in private practice, in that he is in a position to control conditions affecting groups rather than individuals, and yet such groups as would be difficult for the general public health service to reach.

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The Neurological Aspects of Industrial Electrocution

LOUIS J. KARNOSH, M.D., Cleveland, Ohio

IN 1912 Spitzka and Radasch[1] studied the brains of five criminals who were legally electrocuted and these writers described certain lesions which they regarded as being peculiar to electrical shock. Many small hemorrhages were found in the cord, meninges and the substance of the medulla. These authors, however, were very much impressed by the presence of many peculiar perivascular condensations in the ventral horn, the olives and in the formatio reticularis of the brain stem. These lesions were roughly circular in shape, from 30 to 300 micra in diameter and contained a central rarified zone and a peripheral ring of what appeared to be condensed nervous tissue. They concluded that this lesion was due to sudden dilatation and equally sudden constriction of the blood vessels, resulting in hemorrhage, rhexis and coagulation. About the same time Horsely and Clarke described similar lesions. Langworthy[2] claims that these phenomena are due to the intense heat generated in the body, and described the same condition in a case of self-electrocution in a depressed 60 year old male.

There seems to be little agreement concerning demonstrable changes in the brain and cord following electrical shock. In experimental studies made by Langworthy and Kouwenhoven[3] in 1930, these workers were chiefly concerned with the intracellular changes. They noted particularly a marked pyknosis and displacement of the nucleus and a loss of Nissl granules throughout the cytoplasm. On the other hand the findings of Morrison, Weeks and Cobb[4] emphasized the hemorrhage and edema which were found in all cases. Shrinkage of the nerve cell was demonstrated in cases injured by an alternating current. Induced currents produced a swelling of these cells, and some liquifaction and vacuolization. Likewise an induced current caused the cerebral vessels to dilate and the intracranial pressure to rise, while alternating current brought about a constriction of the pial vessels.

All these studies and investigations have not

Read before the Section on Nervous and Mental Diseases, Ohio State Medical Association, at the 86th Annual Meeting, Dayton, Ohio, May 3-4, 1932.

given the clinician any adequate correlation between pathology and the many manifestations or sequella which confront the practitioner. In industrial medicine there are found many objective and subjective conditions which appear to have been induced or aggravated by electrical shock. Because of the variety of these disturbances it is difficult to evaluate the electric-shock factor, for the simple reason that no common denominator has been accepted.

Panse[5] analyzed some 43 cases from the clinical viewpoint. A large group is made up in his series of cases of flaccid paralysis with evidence of anterior horn involvement. In over two-thirds there was only a momentary loss of consciousness or none at all. There was generally a latent period between the injury and the onset of the paralysis. The longer this latency the poorer the prognosis. Parasthesias were usually present almost immediately after the injury. Spastic paralysis and peripheral nerve lesions were rare. Panse explained the latency as being due to secondary edema or vasomotor disturbances. No necropsies were reported.

In a paper presented by Naville[6] at the International Neurological Congress in Berne in 1931 a comprehensive analysis was made of the clinical syndromes arising from industrial electrocution. Hemorrhages in the cord and brain were the most common findings. The author pointed out some interesting clinical signs and warned the clinician that the diversity and intensity of injuries produced by electrical shock give rise to a large range of symptoms and complaints which may be slighted or attributed to remote sources.

In this discussion some of the most striking and varied manifestations of changes due to electrical shock are presented in a few case reports and one demonstration is offered of pathological findings.

CASE REPORTS

CASE I: An electric lineman, aged about 39, while working on a transformer was badly shocked with an alternating current of some 1300 volts. He was unconscious for several hours, then became semi-conscious for another week and finally at the end of four weeks' illness began showing a definite flaccid paralysis in both lower limbs. This paralysis was moderately progressive and at the end of five months there developed signs of bulbar invoivement. Six months after the injury the patient expired with symptoms of respiratory failure.

The brain and the cord was obtained. On gross examination there was a congestion of the meninges and some generalized edema of the brain and cord. There were no signs of actual hemorrhage on the uncut surfaces. On section of the cord there were areas of fresh and old hemorrhage both in the gray and white matter, particularly about the posterior commissure and the antero-lateral horn group. Gross inspection of sections through the medulla showed an engorgement of the veins and petechial hemorrhages fairly recent in appearance in the region of the nucleus ambiguus, and in the median sensory fasiculus.



Figure 1—Section through the cervical portion of the cord in the region of the commissures, showing two types of hemorrhagic lesions. In the upper part are seen two areas having a dense, reticulated appearance while the hemorrhages in the central region appear to be more recent and diffuse. (Mallory's phosphomolybdic acid stain).

Microscopic examination: Sections of the cord stained with Mallory's phosphomolybdic acid, under low power (See Fig. 1) revealed a large number of hemorrhagic areas in the white matter and the gray substance. These masses of red cells were found chiefly about a blood vessel. In the upper portion of this section the vessels were surrounded by a compact, reticulated formation which stained as fibrin or glial tissue. In specific staining these formations appear to be fibrin. Immediately around these reticulated masses there was a definite reactive gliosis, indicating that the lesions were of long standing and quite different from the areas of recent petechial hemorrhage, which can be seen in the lower portion of Fig. 1. It is entirely possible that the lesions described by Spitzka and Radasch, in the fresh cases, were such condensations of blood elements about blood vessels directly injured by the electrical shock.

A high-power examination of the anterior horn region (See Fig. 2) showed, among other phenomena, a contraction of all the neurocytes with prominent perineural spaces. Many of the cells also showed tigrolysis and ghost-cell formation. Considering the degree of degeneration of these nerve cells, there was a surprising absence of satellitosis by granular or gitter cells, such as one sees in a chronic inflammatory or degenerative lesion. Instead the perineural spaces were occupied by collections of red blood cells. The arterioles in this section appeared to have degenerative changes in both the intima and media, appearing cloudy and swollen and granular. Only a few amyloid bodies were found.

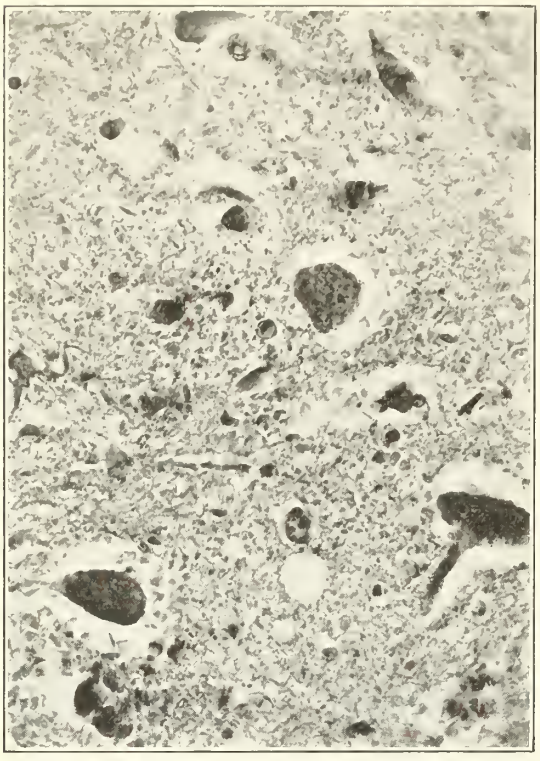


Figure 2—High-power section through the anterior horn region of the cervical cord. There is a definite contraction of all neurocytes and the perineural spaces are occupied by red blood cells. No neuronophagic phenomena can be demonstrated.

Sections of the medulla showed fresh hemorrhages only, and these were found in the nuclei along the floor of the fourth ventricle. One prominent hemorrhage, rather recent, was found near the nucleus ambiguus. The basal ganglia and cortex showed scattered areas of the same nature.

The pathological studies on this case would support the belief that the initial injury caused perivascular hemorrhages and a marked contraction of the ganglionic cells. These cells were not destroyed later by a neuronophagic process. The progressive symptoms appearing later may be due to secondary degeneration of blood vessel walls and a subsequent recurring haematomyelia which may produce death if it involves the medulla.

CASE II: Male, age 52, occupation: bookkeeper. While sitting in a dentist's chair and having an *X*-ray taken of his teeth, he was suddenly thrown to the floor, experienced a sensation of electric shock through his neck and for a few seconds was unconscious or dazed. The room seemed to be on fire. The clothing on his back was burnt slightly and he sustained a second degree burn about 4 cm. in diameter in the interscapular area. Immediately after first aid was given he complained of a severe piercing pain in the small of his back, but had no signs of motor paralysis. After two weeks the pain seemed to localize to the left hip and extended along the outer portion of the left thigh and down as far as the external malleolus.

The neurological examination revealed no abnormal reflex findings. Over the areas supplied by the first and second lumbar segments, involving the upper portions of the gluteus group and extending along the vastus lateralis there was present a fine fibrillary twitching of the muscle tissue and over the same areas there was a definite dulling of sensation of all qualities, particularly, to critical stimuli. This segmental manifestation suggesting an irritative cord lesion, continued for over a year. The fibrillary twitching disappeared but there still remains after two years, a residual hyposthesia in this region. The patient continues to feel some aching in the back and a stiffness on bending or turning.

CASE III: Female, age 34, in January, 1931, after washing her hands and arms and after drying her hands hastily, attempted to pull out of its socket the plug of an electric heater with her right hand. She was shocked and thrown to the floor. After a few moments she recovered herself and her maid assisted her to bed. She complained of lancelating pain in the interscapular area and of weakness in the right shoulder. Two months later a neurological examination demonstrated a segmental syndrome, involving the cervical sixth and seventh segments and the first two thoracic segments. There is an occasional fibrillary spasm of the ulnar group of muscles and of the right pectoralis. She complains of a dull, aching pain in the right axilla and extending along the lateral surfaces of the chest. Under physiotherapy and analgesics this condition has gradually subsided.

That electrical shock may be associated with or complicate the many factors which induce a psychosis is demonstrated in Case IV. A Polish laborer, age 43, while at work on the streets, picked up a live wire and was thrown to the ground and taken to the hospital in an unconscious state. Neither the strength or type of current causing the shock was determined. The patient remained unconscious for a few hours and was discharged four days later with no significant residual symptoms, except a feeling of exhaustion and general weakness. Three months later he become hypochondriacal and nervous, complained of head noises, and within a period of six months these neurotic symptoms flowered into a pronounced melancholia. One year later he was admitted to the psychopathic hospital because he became self-accusatory, paranoid and negativistic. At the present time he is still in the hospital with no signs of improvement in the mental state.

Obviously it would be hazardous to regard the electrical shock as a definite etiological factor. The case is merely presented as a demonstration of the varied responses to electrical shock which may ensue and which may complicate a familiar clinical syndrome.

Electrical shock apparently produces the traumatic elements in certain individuals about which develops that puzzling and frequent enigma which haunts the industrial physician and which is termed post-traumatic psychoneurosis. This is illustrated in CASE V. A young Jewish male, age 26, accidentally touched an eroded portion of a cord leading to a reading lamp. He screamed in fright, recoiled but did not fall to the floor. Subsequently he developed an array of complaints, consisting chiefly of pain in the right elbow which was the site of contact, and a dull ache in the arm and the acromial region. The pain extends often up into the neck and the left side of the head. There are no constant or reliable objective or subjective symptoms, no paralyses or segmental features. In this instance the case in no wise differs from the classic picture of a post-traumatic neurosis, and must be treated as such. There remains, however, a sense of insecurity in such a diagnosis, in the light of experience with other

genuine injury cases with strikingly similar complaints.

CONCLUSIONS

Severe sublethal electrical shock can produce a progressive flaccid paralysis of the limbs and lead eventually to death by bulbar paralysis.

The chief pathological findings are a primary haematomyelia, and a contraction of the nerve cells with definite degeneration but not by a neuronophagic process.

A progressive degeneration of small vessels with continuous secondary hemorrhage indicates that the latent symptoms are due essentially to disease in the blood vessel walls.

The lesions of Spitzka and Radasch are probably perivascular formations of fibrin.

Various clinical syndromes may be due to electrical shock, in two cases the lesions being of spinal and segmental nature.

Mild or severe shock may produce the emotional and mental components of a post-traumatic psychoneurosis without tangible physical findings.

Electrical shock may be an exciting or aggravating factor in the induction of various psychoses.

CITY HOSPITAL.

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Dr. Porter New President of Northwestern Medical Association

Dr. E. H. Porter, Tiffin, was elected president of the Northwestern Ohio Medical Association at the 88th meeting of the association at Lima, October 4. Other officers elected were: First vice president, Dr. V. H. Hedges, Lima; second vice president, Dr. C. M. Harrison, Napoleon; treasurer, Dr. E. L. Brady, Marion, and secretary, Dr. C. E. Hufford, Toledo. Tiffin was chosen as the meeting place for 1933.

The program presented was as follows:

"Toxaemias of Pregnancy", Dr. W. J. Dieckman, Chicago; "The Chronic Sinus in Its Relation to Asthma and Bronchitis—Its Proper Management", Dr. Ferris Smith, Grand Rapids, Michigan; "Some Clinical Applications of Electrocardiography", Dr. Edward D. Spalding, Detroit; "The Treatment of Carcinoma of the Colon and Rectum", Dr. Richard B. Cattell, Boston; "The Roentgenologic Manifestations and Differential Diagnosis of Neoplasms of the Large Intestines", Dr. Harry Weber, Rochester, Minn.; "The Application of the Principles of Nutrition to Daily Practice", Dr. A. Graeme Mitchell, Cincinnati; "The Treatment of Prostatic Obstruction with the Electro-Resectoscope", Dr. Herman L. Kretschmer, Chicago; "The Medical and Surgical Treatment of Gastric and Duodenal Ulcers", Dr. Frank Lahey, Boston.

On the day preceding the meeting, the annual golf tournament of the association was held at the Shawnee Country Club. Dr. J. L. Sampsell, Van Wert, the defending champion retained his championship with a low gross of 80.

Cleveland Academy Sponsors 24 Post-Graduate Lectures

The Cleveland Academy of Medicine has initiated a post-graduate course in "Respiratory Disease" in the form of a series of 24 Friday afternoon lectures at the Academy Building. Dr. H. V. Paryzek, Councilor of the Fifth District, is chairman of the committee in charge of the lectures and demonstrations. The first four lectures were given by Dr. G. S. Shibley, associate professor of medicine, Western Reserve University, on October 7, 14, 21 and 28, on "The Common Cold, Influenza, Lobar Pneumonia and Broncho-Pneumonia". The program for the remaining lectures follows:

November 4 and 11—Abscess of Lung and Bronchiectasis, Dr. Richard Dexter.

November 18—New Growths of the Lung and Bronchi, Dr. M. A. Blankenhorn.

December 2—*X*-ray Diagnosis and Treatment of Pulmonary Malignancy, Dr. David Steele.

December 9 and 16—Pathology of Pulmonary Tuberculosis, Dr. J. C. Placak.

January 13—Laboratory Diagnosis of Pulmonary Tuberculosis, Dr. R. H. Browning.

January 20—Differential Diagnosis of Pulmonary Tuberculosis, Dr. H. H. Brittingham.

January 27—General Treatment of Pulmonary Tuberculosis, Dr. J. C. Placak.

February 3 and 10—Pneumothorax and Oleothorax, Dr. R. C. McKay.

February 17 and 24—Surgical Treatment of Pulmonary Tuberculosis, Dr. S. O. Freedlander.

March 3—Prognosis and Complications of Pulmonary Tuberculosis, Dr. J. C. Placak.

March 10—Intestinal Tuberculosis, Dr. R. H. Browning.

March 17—Laryngeal Tuberculosis, Dr. J. T. Collins.

March 24—Childhood Tuberculosis, Dr. C. W. Burhans.

March 31—Epidemiology of Pulmonary Tuberculosis, Howard Green, executive secretary, Cleveland Health Council.

April 7—Division of Health Tuberculosis Organization, Dr. E. P. Edwards, director of tuberculosis, Division of Health, Cleveland.

The Toledo Academy of Medicine has inaugurated a series of scientific exhibits under the direction of Dr. Frank C. Clifford, chairman, Dr. J. Lester Kobacker, Dr. Nelson D. Morris, Dr. Carll S. Mundy, Dr. A. H. Schade, and Dr. R. C. Young. The exhibits are located in rooms on the first floor of the Academy building so that members can visit them following meetings of the Academy and its special sections. The display will be changed each month. Dr. E. B. Gillette, president of the Academy, was the originator of the idea which has proved most popular among the membership.

The President's Page

A Personal Communication to the Membership from

H. M. Platter, M.D., Columbus, Ohio

The temper of our citizens in these times is by far too complacent. They neglect civic duties and responsibilities and crimes and indiscretions are permitted to be practiced with feeble protest. Law enforcement and law observance is of little or no interest to them. This condition has provoked the comment that "modern civilization is approaching a crisis".

Are we as members of an altruistic profession guilty with the rest? Do we as citizens support good government and protest bad government? Do we as physicians uphold the principles of the code? Are we contributing of our time to advance the interests of scientific medicine?

At no time has there been greater need of understanding of our policies and of the development of a *fraternal* spirit in our membership.

Be "regular fellows" at medical meetings. Lend a helping hand to your society officers and learn what organized medicine is doing for you. Enlist in the cause of good government. Study the records of candidates for public offices and vote intelligently. The medical profession must contribute of its time and talent for the satisfactory solution of many economic and social problems.

We are opposed to nostrums and quackery in medical practice. As citizens we should vigorously oppose them in government. Do you know the attitude of your legislative candidates toward scientific medicine and sound health administration? These questions concern you intimately. They are not partisan.

Policy, Organization and Annual Meeting Problems Considered at October Council Meeting

The Council of the Ohio State Medical Association met in the headquarters office, Columbus, at 1:00 P. M. on Sunday, October 2, 1932.

The Officers and Councilors present were: President, Dr. Platter; President-Elect, Dr. Cummer; Ex-President, Dr. Houser; Treasurer, Dr. Beer; Councilors, Drs. Caldwell, Huston, Klotz, Hein, Paryzek, Davidson, Shanley, Brush, Seiler, Goodman; Dr. Alcorn chairman of the Policy Committee; Dr. Stone and Dr. Upham, members of the Policy Committee; Executive Secretary Martin and Assistant Executive Secretary Nelson.

The minutes of the Council meeting held on July 10, 1932 (published on pages 591 to 594, inclusive, of the August, 1932, issue of *The Journal*), were read, and on *motion* by Dr. Brush, seconded by Dr. Klotz and *carried*, were *approved*.

PLANS FOR 1933 ANNUAL MEETING

Dr. Cummer, chairman of the Council Program Committee, reported on a meeting of his committee on the morning of this day, at which time correspondence was considered from Section officers and progress noted in the formulation of several of the Section programs, in line with the recent rules and regulations of the Council for the program set-up, based on recommendations from the Program Committee. Dr. Cummer also reported on tentative plans for the general sessions on Wednesday of the annual meeting.

CHANGE IN DATES OF 1933 MEETING

The attention of Council was called by Dr. Cummer to the fact that following the action by the Council in fixing the dates for the 1933 annual meeting, that a number of national special societies had changed their dates to meet in Washington, D. C., on the same dates (May 9 and 10, 1933) as the annual meeting of the Ohio State Medical Association. He reported on correspondence with Dr. Davidson, chairman of the Council Committee on Local Arrangements, and the fact that it would be suitable to the Summit County Medical Society and the management of the Mayflower Hotel for the annual meeting of the State Association to be changed from the second week in May to the first week in May, to avoid conflicts with a number of national special societies.

On *motion* by Dr. Cummer, seconded by Dr. Caldwell and *carried*, the dates for the 1933 annual meeting of the Ohio State Medical Association were set for Tuesday and Wednesday, May 2 and 3, instead of Tuesday and Wednesday of the second week as previously decided.

COUNCILOR DISTRICT QUESTIONS

On behalf of a committee consisting of Dr. Houser, chairman, Dr. Cummer, and Dr. Klotz, Dr. Houser submitted the following report:

REPORT

"The President, Dr. H. M. Platter, appointed a special committee, at the last Council meeting, July 10, 1932, for the purpose of making a report on the advisability of rearranging, increasing or changing the present Councilor districts or adding to the present number of Councilors.

"Considerable thought has been given to this matter, not only by your committee, but also by a number of men throughout the state.

"Some months ago, a plan was worked out whereby four Councilors-at-large would be added to the Council, thus increasing the Council by four members, but this plan was finally dropped.

"It was later suggested that some good might be had by extending the term of the past-presidents to three years. Your committee does not approve increasing the term of the past-president, as it has practically the same objection as electing four Councilors-at-large, viz:—past-presidents or Councilors-at-large are not likely to be located geographically so as to aid very much in stimulating greater interest in various county medical societies or organization work in the Councilor district.

"Your committee fully realized that every effort should be made to maintain our organization in its present state of high efficiency and, if found necessary, changes should be made to meet any requirement which may arise.

"The number of Councilor districts may have to be increased in the future, but your committee feels that no change in the number of districts should be made at this time. However, we wish to suggest that each Councilor make a careful study of his district and, where advisable, encourage two or more county societies to hold joint meetings, thus increasing the interest in medical meetings."

Respectfully submitted,

D. C. HOUSER, *Chairman.*
Signed C. L. CUMMER,
O. P. KLOTZ.

On *motion* by Dr. Hein, seconded by Dr. Seiler and *carried*, the Council accepted the report and ordered it placed on file.

APPROVAL OF MAHONING CONSTITUTION

Dr. Cummer, chairman of the Council Committee on Constitutional Conformity, reported on the receipt from the Mahoning County Medical Society of the signed and dated copy of the Constitution and By-Laws of that society, as recently revised in conformity with provisions of the Constitution and By-Laws of the State Association. On *motion* by Dr. Cummer, seconded by Dr. Davidson and *carried*, the Council officially approved the Constitution and By-Laws of the

Mahoning County Medical Society.

COMMITTEE MATTERS

The President, Dr. Platter, called attention to the fact that he had not yet appointed a Special Committee on Mental Hygiene; such a special

committee having been authorized several years ago by the Council and continued since that time.

Following a general discussion, in which attention was called to constructive activity by the committee over a period of years, largely in cooperation with the Policy Committee; on *motion* by Dr. Goodman, seconded by Dr. Cummer and *carried*, the appointment of a Special Committee on Mental Hygiene was deferred until or unless the President felt that such committee should be reappointed, and at which time he would then be authorized to make such appointment.

A report was submitted by Dr. Platter on activities and plans of the newly reorganized Committee on Preventive Medicine and Periodic Health Examinations (formerly the committee on Periodic Health Examinations). He told of conferences and correspondence with Dr. Rowland, chairman, and of the possibility of a conference within the next month. He called attention to the bulletin recently issued by the committee, containing recommendations to the county societies for activities in the field contemplated by the committee. He also explained the tentative plan of the committee to again publish in the *Ohio State Medical Journal*, a revised and up-to-date summary of the periodic health examinations movement.

Dr. Paryzek submitted to the Council a communication received by him from Dr. C. W. Burhans, Lakewood, Ohio, under date of September 24, in regard to child health and welfare movements, and setting forth the members of the Ohio Committee of the American Academy of Pediatrics, having for its purpose contact with child health problems, not only scientific but contact with and information on lay movements in this field, and with the idea of close contact with the Ohio State Medical Association; with the intention of submitting recommendations, from time to time, to the Council of the State Association. Dr. Hein and Dr. Davidson also submitted communications along the same line.

Members of Council expressed themselves as interested in the questions raised by Dr. Burhans, and indicated a willingness and a desire to receive information and recommendations from his Ohio Committee of the American Academy of Pediatrics, from time to time. It was further agreed by the Council that such information and recommendations might properly be considered by the State Association Committee on Preventive Medicine and Periodic Health Examinations and by the Policy Committee, from which committees the Council might receive recommendations as to policy and procedure on such matters as might be submitted by the Ohio Committee of the American Academy of Pediatrics.

PROBLEMS OF WORKMEN'S COMPENSATION

A detailed discussion was had on the adoption recently by the State Industrial Commission, of revised rules and regulations pertaining to physicians, hospitals and nurses; effective September 15, 1932 (published with comments and analysis on pages 659 to 667, inclusive, of the September issue of *The Journal*).

A report was submitted of a series of conferences with officials of the Industrial Commission culminating in a dinner meeting with Industrial Commission officials, also attended, on behalf of the Ohio State Medical Association, by Dr. Platter, Dr. Cummer, Dr. Alcorn, Dr. Upham, Dr. Goodman, and Executive Secretaries Martin and Nelson.

Correspondence with various members on questions of workmen's compensation administration was also discussed. Emphasis was placed on the fine spirit of cooperation between officials of the Industrial Commission and officials of the State Medical Association. Questions were raised in connection with the interpretation and application of some of the new rules and regulations. An incident was related of an inconsistent application of Rule 3, relative to the disallowance of medical fees by the Commission for treatment by more than one physician or surgeon for the same injury or disability over the same period of time.

Dr. Hein called attention to a communication from the Industrial Commission to a claimant who had been referred by the Commission to Dr. Hein for examination. This communication from the Commission, under date of June 13, 1932, was unsigned. It quoted from Dr. Hein's report on which compensation to the claimant was disallowed. Dr. Hein related a number of instances where information from the records of the Commission had caused dissatisfied claimants, when informed that the report of the examining physician was adverse, to become incensed, threatening and on occasions assaulting such physicians. Attention was called to the necessity of the Commission's making provision to safeguard such reports from physicians. Attention was also called to the fact that unless safeguards are provided, some physicians may hesitate to make unbiased adverse reports concerning the condition or disability of claimants on which compensation is disallowed.

On *motion* by Dr. Hein, seconded by Dr. Caldwell and *carried*, the Council requested the Medical Economics Committee to confer with officials of the Industrial Commission on this matter, to emphasize the situation as herein discussed, and to request that proper provision be made to safeguard reports from physicians.

Attention was called to the meeting during the past week in Columbus of the International Association of Industrial Accident Boards and Commissions, and its program in relation to numerous workmen's compensation questions. Attention was called to the prominence of many medical

questions in this program, and to the high esteem in which the medical profession generally is held by governmental administrators in the field of workmen's compensation. As an example, the official comment by Mr. Wellington T. Leonard, chairman of the State Industrial Commission and president of the International Association, was cited.

POLICY AND LEGISLATION

A detailed verbal report was submitted by Dr. Alcorn on conferences of the Policy Committee on the previous day and on the morning of this day, at which time many prospective proposals, under consideration by numerous organizations and agencies for introduction in the next session of the Legislature, were considered; especially those having direct health and medical angles.

Dr. Alcorn reported on the reaffirmation by the committee on policies previously approved by the Council and the House of Delegates on a number of public health questions, workmen's compensation, welfare, hospitals, social insurance, automobiles, cults, allied professions, etc.

On recommendation by the Policy Committee, the Council approved the issuance of the "blue legislative handbook" published two years ago, to the incoming members of the Legislature following the November election, as a summary of policy and attitude of medical organization.

Special attention was called to the activity of the Ohio Hospital Association, and some other groups, in sponsoring legislation to provide for the payment from state funds to hospitals for the care rendered indigent persons injured in automobile accidents. Dr. Alcorn reported that the Policy Committee recommends to the Council that in view of the questions of medical and surgical attendance involved in this bill and in view of the established policy of opposition to a state system of medical service, that the Council withhold endorsement from such proposal. On *motion* by Dr. Huston, seconded by Dr. Davidson and *carried*, the foregoing recommendation specifically, and the general report generally, were approved.

Dr. Upham reported on a recent conference of the Board of Trustees of the American Medical Association with other committees and councils, for a consideration of the growing problem of hospital insurance plans, contract practice, insurance schemes of various kinds and the alarming tendency of corporate and lay practice of medicine. He pointed out the importance of thorough consideration of these various movements, and explained that following recent conferences, detailed information and data was being assembled for submission to the conference in November of the presidents and secretaries of constituent state associations, with the idea of discussing these matters thoroughly and to define a policy; following which, information should be disseminated to the profession generally, and plans made to preserve, whenever possible, the individualistic practice of medicine.

ETHICS AND PROFESSIONAL RELATIONS

Correspondence was submitted from the Judicial Council of the American Medical Association and elsewhere, relative to several ethical questions, with examples of newspaper advertising, newspaper interviews and similar publicity by a number of Ohio physicians. Council discussed these at some length and agreed that in the first instance, official action, if any, properly lies with the local county medical society or academy of which such physicians are members.

MEDICAL DEFENSE AND MALPRACTICE

A report was submitted, showing a serious increase in the number of suits and threats of suits for alleged malpractice, incident, to a considerable extent, to the general unrest and the effort on the part of some patients to profit through a form of blackmail at the expense of physicians. Attention was called to the increased problems of the Medical Defense Committee, the accumulation of legal fees and the development of a number of medical-legal questions. It was agreed that each Councilor, in his visits to the county societies in his district, should emphasize the necessity of "preventive measures" as frequently outlined and clearly set forth by the Medical Defense Committee in its annual report and through other communications.

PUBLICATION PROBLEMS

The President, Dr. Platter, reported on the thorough consideration being given by the Publication Committee to publication costs of *The Journal* and for other printing. He told of unsolicited bids received by the committee from a number of Columbus printing concerns, for the publication of *The Journal* for 1933. He stated that not only figures in bids, but questions of responsibility and thorough compliance with requirements of publication, adherence to routine, etc., were being considered by the committee.

MEMBERSHIP STATISTICS

A report submitted to the Council, including a tabulation of the county medical societies and academies alphabetically, with comparison of present membership and that of last year, showed a total membership in the State Association to date for 1932, of 5,262 as compared with 5,419 on the same date last year, and as compared with a total of 5,489 at the end of 1931.

MISCELLANEOUS

Attention was called to the program for the Ohio Welfare Conference to be held in Columbus on October 4 to 7, inclusive. On *motion* by Dr. Goodman, seconded by Dr. Klotz and *carried*, the President was authorized to appoint an observer

to attend that conference, if he considered it desirable.

Attention was called to comment on page 137 of the June, 1932, issue of the American Medical Association Bulletin, concerning policy and attitude of the National Woman's Auxiliary. The President called to the attention of the Council, a request for a hearing or brief report from officers of the National Woman's Auxiliary during this meeting of the Council. The Council took no action.

Form communications from the National Tuberculosis Association, relative to the forthcoming annual Christmas Seal sale in Ohio in connection with the Ohio Public Health Association, were submitted. On *motion* by Dr. Cummer, seconded by Dr. Klotz and *carried*, the previous policy as to publicity and otherwise was reaffirmed.

Dr. Paryzek reported that at the request of the Board of Directors of the Cleveland Academy of Medicine, he presents for the consideration of the Council, the question of the possibility of a reduction in membership dues in the State Association. He explained the situation of the Cleveland Academy in connection with delinquent dues. There was a general discussion by members of Council, in which the opinion was expressed that the present five dollars per capita annual dues for members in the State Association are sufficiently nominal, and that while no effort should be made at this time to increase dues, they should not be reduced. Other financial details were discussed in this connection.

On *motion* by Dr. Brush, seconded by Dr. Huston and *carried*, the Council expressed its opinion that it is not feasible or desirable to reduce the membership dues in the State Association at this time.

Following the discussion of a number of miscellaneous matters on which no official action was taken, the Council adjourned to meet at the call of the President.

S. J. GOODMAN, M.D.,
Secretary of Council.

Dr. I. P. Seiler, Piketon, Councilor of the Ninth District, was elected president of the Tri-State Medical Association at the recent meeting of that organization at Ashland, Kentucky. Vice presidents elected were Dr. Tunis Nunemaker, Portsmouth; Dr. J. R. Cooper, Ashland, and Dr. W. W. Point, Charleston, West Virginia. Among those who addressed the association was Dr. William D. Porter, Cincinnati.

Middletown—Dr. John C. Stratton was lauded for his accomplishments as a member and president of the local board of education in an article which appeared recently in the American School Board Journal, entitled, "School Board Heads Who Make History in American Education".

New Books Received

Primer on Fractures, second edition, revised and reedited; prepared by the Cooperative Committee of Fractures under the auspices of the Section on Surgery, General and Abdominal and Section on Orthopedic Surgery in cooperation with the Department of Scientific Exhibit of the American Medical Association; an illuserated review of 22 chapters of the treatment of simple fractures; American Medical Association, 535 North Dearborn Street, Chicago.

Treatment of Syphilis, by Jay F. Schamberg, M.D., professor of dermatology and syphilology, Graduate School of Medicine, University of Pennsylvania, and Carroll S. Wright, M.D., professor of dermatology and syphilology, Temple University School of Medicine. D. Appleton and Company, New York City.

The Curative Value of Light, by Edgar Mayer, M.D., medical director of the Northwood Sanatorium and the National Variety Artists Sanatorium, Saranac Lake, N. Y., and consultant in light radiation to the American Medical Association Council; D. Appleton and Company, New York City; price $1.50.

Hospitals and Child Health, a publication of the White House Conference on Child Health and Protection, presenting the findings of the Subcommittee on Hospitals and Dispensaries; the Sub-committee on Convalescent Care and the Subcommittee on Medical Social Service; The Century Company, 353 Fourth Avenue, New York City; price, $2.50.

State Tuberculosis Sanatorium Program

"Early Diagnosis of Tuberculosis", will be the main theme of an all-day meeting which is being planned for Tuesday, November 15, at the Ohio State Sanatorium, Mt. Vernon, under the direction of Dr. F. C. Anderson, medical superintendent of the sanatorium, Dr. J. C. Placak, Cleveland, and Dr. Kennon Dunham, Cincinnati. Reservations for the luncheon are being received by Dr. Anderson. The following program has been arranged.

10 a. m. to 1 p. m.—*X*-ray Exhibit, Dr. Kennon Dunham, Cincinnati; Diagnosis, Dr. J. C. Placak, Cleveland; Differential Diagnosis, Dr. W. C. Breidenbach, Dayton; Routine Management, Dr. F. C. Anderson, Mt. Vernon.

1 p. m.—Luncheon.

2:30 p. m. to 4:30 p. m.—Children, Dr. C. L. Hyde, East Akron; Surgery, Dr. S. C. Friedlander, Cleveland; Prevention, Dr. C. O. Probst, Columbus.

Oberlin—Dr. F. M. Bond, graduate of Rush Medical College, who has been on the staff of the Letterman General Hospital, San Francisco, as a member of the medical corps of the U.S. Army, has opened offices here for general practice. He is a graduate of Oberlin College.

Interesting Program Arranged For Annual Health Commissioners Conference in Columbus, November 16 to 18

An interesting and varied preliminary program for the Thirteenth Annual Conference of Ohio Health Commissioners with the State Department of Health, to be held at the Deshler-Wallick Hotel, Columbus, November 16, 17 and 18, has been arranged under the direction of Dr. E. R. Shaffer, chief of the Bureau of Local Health Organization, State Department of Health. All physicians are welcome to these sessions.

Several phases of public health work which have not been discussed at recent conferences of the health commissioners of the state have been scheduled, making the program for this year's gathering a departure in several respects from programs presented in past years.

Several additional addresses are being planned and will be given a definite place on the program as soon as the persons invited to deliver them have indicated their acceptance.

The conference will be officially opened on Wednesday, November 16, at 2 p. m. by Governor White. Wednesday morning will be devoted to the registration of commissioners, nurses, health department employes, and guests.

Following is the tentative program for the conference:

Wednesday, November 16

GENERAL SESSION

2 p. m.—Address of Welcome, Honorable George White, Governor of Ohio.

2:30 p. m.—Annual Address, H. G. Southard, M.D., State Director of Health.

3 p. m.—Mutual Ideals of the Medical Profession, H. M. Platter, M.D., Columbus, president of the Ohio State Medical Association.

3:30 p. m.—Teaching Public Health to Lay Organizations, Mrs. Mary Cartwright, lecturer, State Department of Health.

3:50 p. m.—How Non-Official Agencies May Assist in Official Public Health Administration, Charles S. Berry, Ph.D., director, Bureau of Special Education, Ohio State University.

Thursday, November 17

GENERAL SESSION

O. M. Craven, M.D., health commissioner, Springfield, Presiding

9 a. m.—Chairman's remarks.

9:10 a. m.—Address, E. R. Hiatt, M.D., health commissioner, Miami County.

9:30 a. m.—General discussion.

9:40 a. m.—Conducting a Health Center in a Small City, O. D. Tatje, M.D., health commissioner, Portsmouth.

10 a. m.—General discussion.

10:10 a. m.—Immunology in the Control of Communicable Diseases, Charles A. Doan, M.D., director, Department of Medical and Surgical Research, Ohio State University.

12 noon—Public health nurses luncheon and roundtable discussion.

GENERAL SESSION

Public Health Nursing Program

Miss Sue Z. McCracken, R.N., district supervisor, Cleveland, Visiting Nurses Association, Lakewood.

2 p. m.—Chairman's address.

2:10 p. m.—Qualifications of Nurses Holding Responsible Public Health Positions (tentative), Miss Marguerite Fagen, R.N., president, Ohio State Nurses' Association, Cincinnati.

2:30 p. m.—Importance of Registration of Graduate Nurses, Miss Clara F. Brouse, R.N., chief examiner, Nurse Registration, State Medical Board, Columbus.

2:50 p. m.—General discussion.

3 p. m.—Mental Hygiene of Childhood, Henry C. Schumacher, M.D., associate professor, Western Reserve University, Cleveland.

3:45 p. m.—Periodic Health Examinations, V. C. Rowland, M.D., Cleveland, chairman, Committee on Preventive Medicine and Periodic Health Examinations, Ohio State Medical Association.

4:15 p. m.—General discussion, led by Beatrice Hagen, M.D., health commissioner, Muskingum County.

INFORMAL DINNER SESSION

Annual meeting of Ohio Federation of Public Health Officials, with F. M. Houghtaling, M.D., president, presiding.

6 p. m.—Dinner.

7 p. m.—Business Session, including reports of Committees, election of officers, appointment of committees, and general discussion.

Friday, November 18

GENERAL SESSION

Frank C. Anderson, M.D., superintendent, Ohio State Sanatorium, Mt. Vernon, presiding.

9 a. m.—Chairman's remarks.

9:30 a. m.—Instructing Medical Students in Preventive Medicine, Thomas J. LeBlanc, M.D., associate professor, University of Cincinnati.

10:15 a. m.—The Role of the Physician in Public Health Procedures, J. A. Doull, M.D., head of

the Department of Hygiene and Bacteriology, Western Reserve University.

GENERAL SESSION

James E. Bauman, assistant state director of health, presiding.

2 p. m.—Chairman's remarks.

2:10 p. m.—Food Poisoning, Leo F. Ey, chief, Division of Laboratories, State Department of Health.

2:30 p. m.—Discussion, led by Harold J. Knapp, M.D., health commissioner, Cleveland.

2:45 p. m.—A Rural Sanitation Program, R. H. Markwith, M.D., health commissioner, Summit County.

3 p. m.—Discussion.

3:15 p. m.—The State in the Control of Venereal Diseases, R. W. DeCrow, M.D., chief, Bureau of Venereal Diseases, State Department of Health.

3:30 p. m.—Discussion.

3:40 p. m.—A Resume of Engineering Problems of Interest, F. H. Waring, chief engineer, State Department of Health.

4 p. m.—General Discussion.

4:15—Announcements and adjournment.

News Notes From County Societies and Academies

First District

ACADEMY OF MEDICINE OF CINCINNATI

(Geo. B. Topmoeller, M.D., Secretary)

September 26—Memorial service honoring the late Dr. Charles L. Bonifield. Addresses: "Doctor Bonifield, The Man", Dr. William D. Porter; "Doctor Bonifield, The Surgeon", Dr. Robert Carothers; "Doctor Bonifield, The Teacher", Dr. J. D. Miller. Annual reports of standing committees. Address of the retiring president, Dr. William M. Doughty; Installation of the following new officers for the year 1932-1933: President, Dr. Parke G. Smith; president-elect, Dr. Samuel Iglauer; secretary, Dr. George B. Topmoeler; treasurer, Dr. E. O. Swartz. Inaugural address of the incoming president, Dr. Parke G. Smith.

October 3—General session. Program: "Cerebral Hemorrhage In the Newborn", Dr. H. F. Downing; discussions by Dr. H. L. Woodward and Dr. Albert Bell; "Adequate Antenatal Care as a Means of Reducing the Mortality Rate in Obstetrics", Dr. James M. Pierce; discussions by Dr. H. L. Woodward and Dr. Samuel Rothenberg.

October 10—General session. Program: "Nasal Sinuses; Practical Consideration of General Interest", Dr. Henry M. Goodyear; discussions by Dr. Charles C. Jones and Dr. H. H. Vail; "One Year of Prematures at the Cincinnati General Hospital", Dr. Edward A. Wagner; discussions by Dr. Victor Greenebaum and Dr. William Cook.

October 17—General Session. Program: "Observations on Addisin", Dr. Roger Morris; discussions by Dr. Alfred Friedlander and Dr. Leon Schiff; "Acute Diverticulitis of the Sigmoid", Dr. V. B. Roberts; discussions by Dr. Otto Seibert and Dr. C. C. Fihe.

October 24—Clinical demonstrations and scientific exhibits as follows: "Experimental Gastric Ulcer Due to Bile Salts", Dr. Leon Schmidt and Dr. Shiro Tashiro; "The Latest Studies in Tularemia", Dr. Lee Foshay; "The Maggot Treatment of Osteomyelitis", Dr. Ralph Carothers; "The Use of Gastric Juice in the Treatment of Pernicious Anemia", Dr. Roger Morris and Dr. Leon Schiff; "The Differential Diagnosis of Abdominal Tumors", Dr. Samuel Brown; "Studies of Acute Enteritis in Children", Dr. Merlin Cooper. Address, "Urogenital Infections", Dr. Frank Hinman, San Francisco.

October 31—General Session. Program: "Desmogenous Tumors", Dr. Albert Freiberg; "Some Applications of Blood Chemistry to the General Practice of Medicine", Dr. G. E. Cullen.

Adams County Medical Society met in regular session October 19 at West Union. Dr. J. E. Pirrung and Dr. W. D. Haines, both of Cincinnati, were the guest speakers. Dr. Pirrung discussed "Surgery of the Colon", and Dr. Haines "Diverticultitis". A paper on "Hemorrhagic Pancreatitis" was read by Dr. F. C. Leeds, Winchester, and Dr. S. W. Cartwright, Manchester, presented one on "First Aid in Country Practice". Wives of the members were entertained by the wives of physicians of West Union.—Bulletin.

Clermont County Medical Society met at Owensville October 19 in regular session. Following a short business session, Dr. Charles E. Howard, Cincinnati, presented a paper on "Rectal Hemorrhage", and Dr. H. J. Lavender, Cincinnati, read one on "Modern Aspects of Ringworm".—Bulletin.

Clinton County Medical Society was addressed by Dr. J. E. Pirrung, Cincinnati, at its regular meeting on October 4. Dr. Pirrung spoke on "Sur-

gical Aspects of Colon Diseases".—W. L. Regan, M.D., Secretary.

Fayette County Medical Society at its regular meeting on October 6 at Washington C. H., was addressed by Dr. Jonathan Forman, Columbus, on "Allergy". There was a large attendance and an interesting discussion following the principal address.—J. F. Wilson, M.D., Secretary.

Warren County Medical Society met in regular session on October 4 at Lebanon. The principal address of the program was made by Dr. R. D. Arn, Dayton. Dr. Arn discussed "Surgery in Vascular Disease".—News Clipping.

Second District

Greene County Medical Society gave a farewell testimonial dinner September 22 at Geyer's Restaurant, Xenia, in honor of Dr. R. H. Grube, retiring president of the society, who plans to move to Long Beach, California, in the near future. Dr. Grube in retiring concluded 30 years of active medical practice and many years of active service in public health work, having served since 1909 as health commissioner of Xenia, health commissioner of Greene County, and for five years on the old State Board of Health. Floral tributes were presented to him by Dr. Ben R. McClellan on behalf of the medical society and by Dr. A. C. Messenger on behalf of the Ohio Soldiers' and Sailors' Orphans' Home, Dr. Grube having been one of the founders of the medical and surgical consulting staff at the home more than 25 years ago. James E. Bauman, assistant state director of health, eulogized Dr. Grube for his services in the public health field.—News clipping.

The October meeting of the society was held October 6. Dr. C. L. Minor, Springfield, was the guest speaker, discussing "Eye, Ear, Nose and Throat Conditions in Relation to Systemic Diseases".—News clipping.

Miami County Medical Society held its October meeting on October 7 at the Piqua Memorial Hospital. The program consisted of an address by Dr. Milton B. Cohen, Cleveland, on "The Relation of Allergy to the Problems of the Practicing Physician". Dinner was served following the meeting.—Bulletin.

Montgomery County Medical Society opened its fall activities October 7 when a complimentary dinner was given by the Good Samaritan Hospital, Dayton, and a large attendance heard an address by Dr. Warren T. Vaughn, Richmond, Virginia, on "Allergy As a General Medical Problem".—Bulletin.

Third District

Auglaize County Medical Society met in regular bi-monthly session at the Court House, Wapakoneta, on October 13. The special feature of the program was an address by Dr. E. A. Peterson, a member of the faculty of the School of Medicine, Western Reserve University. He discussed 'The Doctor's Responsibility in the Field of Pediatrics", touching on the prevention and cure of disease by measures of personal medical treatment and the development of health and vigor in the growing child. Asserting "a deep and abiding faith in the private practitioner as the cornerstone of any sound Temple of Health administration", Dr. Peterson outlined a health program for children which begins with the diet and health of the mother before childbirth and continues the careful supervision of health and development in infancy and throughout school life, as the best means of producing sound adult health so necessary to success in life. He insisted this program be carried out by private physicians where possible and by county health agencies among the indigent. The speaker urged the county medical society to lead in the inauguration of such a program with the help of the health departments, schools, and welfare agencies. There was a large attendance, including a number of physicians from Mercer and Shelby counties. Among the guests were about 50 mothers, representatives from the schools of the county and of the health departments. Some of these took part in the discussion which followed the address.—C. C. Berlin, M.D., Secretary.

Hancock County Medical Society held its regular monthly meeting on September 7 at the Findlay Country Club. The principal speaker was Dr. William Gordon, Detroit, formerly of Findlay. Dr. Gordon spoke on "Agranulocytosis", an analysis of some original research on his part at the Harper Hospital, Detroit.—H. O. Crosby, M.D., secretary.

The regular October meeting of the society was held on October 12 at the Elks' Home, Findlay. A very interesting paper was presented by Dr. J. Lester Kobacher, Toledo, on "Heart Disease".—H. O. Crosby, M.D., Secretary.

Hardin County Medical Society was addressed by Dr. Norris W. Gillette, Toledo, at its regular meeting on September 22 at the Kenton Cafe. Dr. Gillette discussed "Goiter" and presented lantern slides and motion pictures on the subject.—News clipping.

Logan County Medical Society held a dinner meeting October 7 at the Chamber of Commerce headquarters, Bellefontaine. Dr. W. S. Phillips, Bellecenter, opened the program with a paper on "Smallpox". A general discussion concluded the meeting.—News Clipping.

Van Wert County Medical Society held its regular October meeting on October 11 in conjunction with the staff meeting of the Van Wert Hospital. The guest speaker was Dr. B. W. Rhamy, Fort Wayne, Ind., who presented an interesting paper

on practical laboratory methods and their coordination with the private practice of the physician. Many members of the society reported on the Post-Graduate Lectures given by Dr. Julius Bauer under the auspices of the Lima and Allen County Medical Society. Funds had been appropriated by the society whereby each member could attend at least two of the lectures. A majority of the members, however, attended the entire course of addresses.—News clipping.

Fourth District

ACADEMY OF MEDICINE OF TOLEDO AND LUCAS COUNTY

(A. P. Hancuff, M.D., Secretary)

October 7—General Session. Debate: "Resolved That the Standardization of Medical Fees is Desirable". Affirmative side, Dr. J. Lester Kobacker; negative side, Dr. F. N. Nagel. Affirmative discussants, Drs. A. P. Hancuff, L. A. Levison and N. D. Morris; negative discussants, Drs. E. J. McCormick, J. A. Muenzer and J. T. Murphy.

October 14—Section of Pathology, Experimental Medicine and Bacteriology. Program: "Sensitization", Dr. John P. Parsons, associate professor of pediatrics, University of Michigan.

October 21—Medical Section. Program: "Heat, Humidity and Colds", Dr. Leonard Nippe; "Ulcerative Colitis", Dr. H. F. Howe; "Varicose Ulcers", Dr. R. S. Gillette.

October 28—Surgical Section. Program: "The Surgical Teratment of Congenital Anomalies of the Abdomen", Dr. E. R. Marker; "Prolapse of the Rectum", Dr. J. F. Whitacre.

Wood County Medical Society resumed its regular monthly meetings with a dinner meeting on September 15 at the Woman's Club. The program was presented by Dr. W. A. Neill and Dr. J. H. Magoun, both of Toledo. Dr. Neill spoke on "Recent Figures and Facts of Cancer Cases", and Dr. Magoun on "Diagnosis and Management of Malignancy of the G. U. Tract". The meeting was well attended. Among the guests were Dr. F. W. Clement, Dr. William Mefley and Dr. Theodore Zbinden, all of Toledo; Dr. R. E. Rasor, Bloomdale, and Dr. Edward Mercer, Bowling Green.—R. N. Whitehead, M.D., correspondent.

Fifth District

ACADEMY OF MEDICINE OF CLEVELAND

(Clarence H. Heyman, M.D., Secretary)

October 7—Clinical and Pathological Section. Program at Lakeside Hospital.

October 14—Experimental Medicine Section and Cleveland Section of the Society for Experimental Biology and Medicine. Program at Institute of Pathology: "The Dick Reaction in Different Racial Groups", H. H. Pevaroff and Sarah M. Hindman, by invitation; "Electrophoresis of Sensitized Pneumococcus Strains", R. L. Thompson, by invitation; "Correlation of Certain Characteristics in the Streptococcus Group", R. L. Thompson and Dr. E. McGrail; "Seasonal Distribution of Pneumonia—Experience of the Medical Clinic, Johns Hopkins Hospital, 1910-29", Dr. G. E. Harmon; "Stability of Resistance to the Common Cold", Dr. J. A. Doull.

October 21—Joint meeting of the Cleveland Medical Library Association, the Medical Department Reserve Officers of Cleveland, and the Academy of Medicine. Address: "Some Medical Incidents in the U. S. Army", Major General Hugh A. Drum, commander, Fifth Corps Area, U.S.A.

October 26—Obstetrical and Gynecological Section. Program: "Pathology of Cancer of the Cervix", Dr. Harry Goldblatt; "Surgery and Radium in the Treatment of Cancer of the Cervix", Dr. A. Strauss and Dr. L. A. Pomeroy; "The Role of Roentgen Therapy in the Treatment of Cancer of the Cervix", Dr. U. V. Portmann.

October 26—Industrial Medicine and Orthopedic Section. Program: 'Some Present Day Problems of Industrial Medicine and Surgery", Dr. W. Irving Clark, Worcester, Massachusetts; "Osteoperiosteal Reaction to Infection", Dr. Rudolph Reich.

October 28—Ophthalmological and Oto-Laryngological Section. Clinical program at Charity Hospital.

Ashtabula County Medical Society held its regular meeting September 13 at the Hotel Ashtabula, Ashtabula. Following dinner, Dr. Arthur Thomas, Youngstown, addressed the society on "Certain Phases of Pediatrics", and Dr. A. M. Rovin, Detroit, on "Endocrinological Aspects of Immunity". Dr. Charles H. Edel, Kingsville, was elected to membership.—E. H. Merrell, M.D., Secretary.

Lorain County Medical Society held a dinner meeting October 11 at Moore's Tavern, near Amherst. The principal speaker was Dr. C. D. Christie, Cleveland, who talked on "Some of the Problems of Diabetes". The paper was discussed by Dr. H. C. Stevens, Elyria.—Bulletin.

Sixth District

Annual meeting of the *Sixth Councilor District* was held October 6 in Youngstown with a large attendance. At the afternoon session, held in the Elks' Club, the following program was presented: "Malignancy of the Thyroid", Dr. Armin Elsaesser, Youngstown; "*X*-ray Diagnosis of Gall Bladder Disease", Dr. John Heberding, Youngstown; "*X*-ray Findings in Low Back Conditions", Dr. E. C. Baker, Youngstown; "Causes of Increased

Density in the Upper Third of the Lung", Dr. O. D. Hudnut, Youngstown; discussion by Dr. M. H. Bachman and Dr. S. J. Tamarkin, Youngstown; "Modern Concepts in the Management of Certain Types of Heart Disease", Dr. Roy W. Scott, professor of medicine, Western Reserve University. The annual banquet and evening session were held at the Youngstown Club. The principal speaker at the evening session was Dr. Thomas McCrae, professor of medicine, Jefferson Medical College, Philadelphia. Dr. McCrae discussed the subject, "Methods in Diagnosis".

Ashland County Medical Society was entertained at a dinner on September 23 at the home of Dr. W. F. Emery in honor of his 60th birthday. Following the dinner, Dr. Emery was presented with a bronze desk lamp. The guest speaker was Dr. George F. Zinninger, Canton, whose talk was entitled "Counsels, Ideals and Recollections of Sir William Osler". At the brief business session Dr. G. D. Fridline was elected to membership.—News clipping.

Mahoning County Medical Society was addressed on September 20 at the Youngstown Club by Dr. Meredith F. Campbell, member of the urologic staffs at New York University Medical School, Columbia University Medical School, and Bellevue Hospital, New York City. Dr. Campbell spoke on "Chronic Urinary Infections in Infants and Children".—Bulletin.

Portage County Medical Society met in regular session October 6 at the office of Dr. W. B. Andrews, Kent. Dr. Harry G. Sloan, Cleveland, was the principal speaker, discussing, "The Diagnosis of Acute Abdominal Disorders". A discussion of the paper was opened by Dr. P. H. Zinkhan. Dr. J. S. Deyell, Ravenna, presented a case report.—Bulletin.

Stark County Medical Society held its regular meeting October 11 at the Molly Stark Sanatorium. Following a complimentary dinner by the sanatorium staff and Dr. E. B. Pierce, superintendent, a program covering various phases of tuberculosis was presented.—Bulletin.

Summit County Medical Society met on October 4 at the Mayflower Hotel, Akron, with members of the Summit County Dental Society as its guests. The guest speakers were W. J. Burns, Detroit, executive secretary, Wayne County (Detroit) Medical Society, and H. Van Y. Caldwell, Cleveland, executive secretary, Cleveland Academy of Medicine. Each spoke on the subject, "The Cancer of the Medical and Dental Professions".—Bulletin.

Wayne County Medical Society met in regular session on October 11 at Wooster. The principal speaker was Dr. F. S. Gibson, Cleveland. There was a large attendance.—Bulletin.

Seventh District

Belmont County Medical Society held its monthly meeting October 6 at the Belmont Hills Country Club. Dr. H. M. Platter, Columbus, president of the Ohio State Medical Association, was a guest of the society. Dr. Platter spoke briefly on organization problems and activities. — News clipping.

Columbiana County Medical Society met on October 13 at Lisbon. Dr. F. W. Trader, Columbiana, read a paper on "The Acute Surgical Abdomen". The discussion was led by Dr. Chester W. DeWalt and Dr. H. H. Bookwalter.—T. T. Church, M.D., Secretary.

Tuscarawas County Medical Society met in regular session on September 8 at the Buckeye Hotel, Uhrichsville. Dr. R. J. Foster, New Philadelphia, read a paper on "Referred and True Abdominal Pains". A paper also was presented by Dr. George Sackett, New Philadelphia.—News clipping.

Eighth District

Athens County Medical Society met October 3 at the country home of Dr. T. A. Copeland, near Stewart. The principal address was made by Dr. George I. Nelson, Columbus, following a dinner.

The September meeting of the society was held on September 8 at the American Legion Home, Athens, with Dr. J. J. Coons, Columbus, as the principal essayist. Dr. Coons presented a paper on "Diseases of the Gall Bladder and Stomach". Twenty members attended the luncheon and meeting.—News clipping.

Fairfield County Medical Society held a luncheon meeting September 7 at the Elks' Home, Lancaster. The program consisted of discussions on tuberculosis, led by Dr. C. H. Benson, Columbus.—News clipping.

Guernsey County Medical Society met in regular semi-monthly session October 6 in the Romance Retsaurant at Cambridge with a large attendance. Dr. Carl D. Hoy, Columbus, was the guest speaker, discussing "Fractures".

At its meeting on September 15, the society entertained the wives of its members at the Fireplace Inn, west of Cambridge. The evening was spent in social diversions.—O. R. Jones, M.D., Secretary.

Perry County Medical Society met in regular session September 19 at the Park Hotel, New Lexington. Following a luncheon, the society was addressed by Dr. Joseph Price and Dr. John J. Wenzke, both of Columbus, on the subject, "The Ideal Anesthetic".—F. J. Crosbie, M.D., secretary.

Perry County Medical Society at its regular luncheon meeting October 17 at the Park Hotel, New Lexington, was addressed by Dr. A. Henry

Dunn, Columbus, on "The Inflammatory Cervix". The program was in charge of Dr. W. D. Porterfield, Junction City.—Bulletin.

Ninth District

Jackson County Medical Society was addressed on September 14 at Jackson by Dr. Tunis Nunemaker, Portsmouth.—News clipping.

Scioto County—The regular monthly meeting of the Hempstead Academy of Medicine was held October 10 at the Nurses' Home. Dr. Russell G. Means, Columbus, was the guest speaker. He presented a paper on "Sinus Infection in Children with Chest Complications". A buffet luncheon was served following the program.—Bulletin.

Tenth District

COLUMBUS ACADEMY OF MEDICINE

(John H. Mitchell, M.D., Secretary)

September 19—Fall and winter activities of the Columbus Academy of Medicine were resumed on Monday evening, September 19, with a largely attended meeting of the Academy at the Columbus Public Library.

Many members of the Columbus dental, pharmacy and veterinarian professions were guests of the Academy, having been invited to hear the guest speakers of the evening—Dr. James M. Doran, federal prohibition commissioner, R. E. Joyce, supervisor of permits for the Sixth District composed of the states of Ohio, Michigan, Kentucky and Tennessee, and Dr. H. W. Moore, of the research division of the Bureau of Industrial Alcohol.

Dr. Doran reviewed briefly the history of the Bureau of Industrial Alcohol; the purposes for which it was created, and how it functions. He explained not only its operation relative to the regulation of alcohol and liquor used for professional purposes, but also its functions in regulating the amount of alcohol used in industry. Dr. Doran said that the government is receiving splendid cooperation from all professional groups and that a minimum of difficulty is encountered in supervising the approximately 130,000 permitees in the nation. He declared that the bureau is endeavoring to work with physicians, dentists, druggists, etc., and trying to interpret and enforce the laws and regulations which have been promulgated in such a way that as little burden and red-tape as possible will be inflicted on those holding permits. Dr. Doran told of the bureau's cooperation with the American Medical Association and various state medical, dental, and pharmaceutical associations, as well as individual physicians, dentists and druggists, in attempting to have inequalities of the regulations removed and to guard against restrictions which would interfere with the professional activities of law-abiding holders of permits. The Commissioner pointed out that the professional groups must realize that some regulation and supervision is necessary, and that a continuance of the present spirit of cooperation between the great majority of the professional men and the bureau will prevent additional restrictions or burdensome paper work on the part of permitees.

Mr. Joyce spoke briefly on the work of his office in Cincinnati which handles all permits for the Sixth District. He urged cooperation on the part of the professional groups and declared that his office is ready at all times to work with physicians, dentists, etc., and to see that solutions for individual problems are solved, if possible, promptly and satisfactorily.

Dr. Moore explained some of the uses of alcohol in industry and called attention to the exhibit of some of the products in the manufacture of which alcohol plays a leading part.

September 26—General Session. Program: "Use of Adhesive Plaster in the Treatment of Burns", Dr. G. A. Lawrence, Westerville. Talking motion picture on the manufacture and use of insulin.

October 3—General session at the Franklin County Sanatorium. Program: "The Main Function of a County Sanatorium", Dr. C. O. Probst; "The *X*-ray as an Aid to Selecting Suitable Cases for Surgery and the Operation Indicated", Dr. H. F. Fulton; "Air Compression of the Lung", Dr. M. D. Miller; "Phrenic Interruption—Chest Surgery", Dr. J. M. Dunn.

October 10—General session. Program: "Significance of the Iodine Content of the Blood", Dr. George Curtis, professor of experimental surgery, Ohio State University.

October 17—Clinical demonstrations at Mt. Carmel Hospital.

October 24—General session. Program: "Obstetrics", Dr. Arthur H. Bill, professor of obstetrics, Western Reserve University.

October 31—Program by General Practitioners' Section.

Crawford County Medical Society met in regular session on October 3 at the Elks' Club, Bucyrus. Dr. Thomas L. Ramsey and Dr. John T. Murphy, both of Toledo, were the guest speakers. Dr. Ramsey discussed "Pathological Conditions of the Testicle" and Dr. Murphy presented a paper on "*X*-ray Therapy in Testicular Neoplasms". A buffet supper was served following the program. —Bulletin.

Ross County Medical Society held its first fall meeting on September 1 at the Warner Hotel, Chillicothe. Dr. Samuel Sproat presented the principal paper, discussing "Surgical Progress". —News clipping.

Deaths in Ohio

John A. Bolton, M.D., Cleveland; School of Medicine, Western Reserve University, 1910; aged 53; died September 23 from brain tumor. Dr. Bolton, a native of Hancock County, began the practice of medicine at Wapakoneta, moving to Cleveland about 22 years ago. He is survived by his widow, four sisters and two brothers.

William G. Brown, M.D., Lewisburg; Miami Medical College, Cincinnati, 1885; aged 77; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died September 28 of paralysis. Dr. Brown had practiced at Lewisburg since his graduation from medical school. He was a member of the Preble County Board of Health, former member of the Lewisburg board of education and former county pension examiner. Dr. Brown was an active member of the Masonic Lodge. Surviving are his widow and one daughter.

John S. Cross, M.D., Youngstown; Cleveland Pulte Medical College, 1898; aged 59; died October 5 of apoplexy. Dr. Cross formerly practiced in Niles, moving to Youngstown in 1905. He is survived by his widow and three daughters.

William R. Hosick, M.D., Granville; Medical College of Ohio, Cincinnati, 1887; aged 73; died September 20 of abscess of the gall bladder. He had practiced in Granville for the past 13 years and previous to that in Plainfield, Adamsville and Newcomerstown. Surviving are his widow and two daughters.

Jay H. Miller, M.D., Wauseon; Hospital College of Medicine, Louisville, Ky., 1888; aged 70; member of the Ohio State Medical Association and the American Medical Association; died September 8 following an extended illness. Dr. Miller located in Wauseon in 1901, having practiced previously in Kentucky and Texas. He was a member of the Masonic and Pythian lodges. Surviving are his widow, three daughters and one son.

John G. Noland, M.D., Berea; Cleveland College of Medicine and Surgery, 1888; aged 79; died September 9. Dr. Noland was a native of Washington County and practiced at Marietta before locating in Berea. Surviving are his widow, two brothers and one sister.

Ira H. Pardee, M.D., Ashtabula; Pulte Medical College, Cincinnati, 1889; aged 73; former member of the Ohio State Medical Association and the American Medical Association; died September 3 of cancer of the stomach. For the past 43 years Dr. Pardee had been active in medical, political and civic circles in Ashtabula. He served as mayor of the city from 1912 to 1916; was a former member of the city council and former township park trustee. Dr. Pardee was a member of the Masonic Lodge and until recently was a trustee of the Ashtabula General Hospital. Surviving are his widow, two sons, one of whom is Dr. A. J. Pardee, Ashtabula, one sister and one brother.

Herman J. Peters, M.D., Ragersville; Medical College of Ohio, Cincinnati, 1870; aged 90; died September 6 following a heart attack. Dr. Peters was a member of the G. A. R. and the Lodge of Elks. He was formerly postmaster of Ragersville and a justice of the peace. Surviving are his widow, four daughters, five sons, one brother and one sister.

James M. Rector, M.D., Columbus; Ohio Medical University, Columbus, 1903; aged 55; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died September 17 following a cerebral hemorrhage. Dr. Rector, a native of Circleville, had practiced in Columbus since his graduation from medical school. He was a veteran of the Spanish-American War, a member of the American College of Physicians, Alpha Kappa Kappa fraternity, the Presbyterian church, Columbus Country Club and the Crichton Club. Surviving are his widow, one son, one daughter, two brothers and one sister.

Edward H. Schild, M.D., Canton; University of Maryland School of Medicine and College of Physicians and Surgeons, Baltimore, 1900; aged 65; member of the Ohio State Medical Association and Fellow of the American Medical Association; died September 3 of angina pectoris. Dr. Schild, a native of New York City, entered medical school after graduating from Baltimore City College and a technical school at Dresden, Germany. While practicing in Baltimore, following graduation from medical school, Dr. Schild served on the staffs of the Baltimore Eye and Ear Hospital and the Johns Hopkins Hospital. He moved to Canton in 1905. Dr. Schild was a Fellow of the American Academy of Ophthalmology and Oto-Laryngology; a member of the Lutheran Church, and of various Masonic bodies. One daughter survives.

Henry C. Schoepfle, M.D., Sandusky; University of Michigan Medical School, 1897; aged 57; mem-

ber of the Ohio State Medical Association and a Fellow of the American Medical Association; died September 13 after a brief illness. Dr. Schoepfle started the practice of medicine in Sandusky in 1899 after two years of study abroad. He served in the Spanish-American War in the medical corps. Dr. Schoepfle served as county coroner for several years and was at one time city health commissioner. He was a member of various Masonic bodies; the Elks' Lodge; the Plum Brook Country Club, and of the staffs of Providence and Good Samaritan hospitals. Surviving are his widow, one daughter, two sons, two sisters and three brothers.

Henry Snow, M.D., Norwood; Pulte Medical College, Cincinnati, 1891; aged 72; died October 9. Dr. Snow was a professor at the medical school from which he was graduated until 1905. Since then he had been in active practice. He was a member of the staff at Bethesda Hospital, Cincinnati. Surviving are his widow, two daughters, and two sons, one of whom is Dr. Henry Snow, Jr., Dayton.

Wilhelm H. Vorbau, M.D., Lima; Ohio State University College of Medicine, 1913; aged 44; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died October 7 of a sudden heart attack. Dr. Vorbau at the time of his death was superintendent of the State Hospital for the Criminally Insane, Lima. He joined the medical staff of the hospital in 1915 where he served 11 years as physician and assistant superintendent. In 1926 he was appointed superintendent for the Institution for Feeble Minded at Orient but served there only six months, being named head of the Lima institution upon the death of Dr. Charles H. Clark. Dr. Vorbau was a member of the American Psychiatric Association. He is survived by his widow.

KNOWN IN OHIO

Louis M. Cusher, M.D., Edinburg, Texas; Miami Medical College, Cincinnati, 1905; aged 62; former member of the Ohio State Medical Association and a Fellow of the American Medical Association; died September 12 of heart disease. Dr. Cusher practiced in Cincinnati until the World War when he served overseas in the medical corps with the rank of captain. Following the war, he was chief medical examiner for the Veterans' Bureau for Ohio, Indiana and Kentucky, with headquarters at Cincinnati. In 1927 he was transferred to the Veterans' Hospital, Waukesha, Wisconsin. A year or so ago he moved to Texas where he engaged in fruit growing. Surviving are one son and one daughter.

Elizabeth Cheatham Fairbanks, M.D., Pelee Island, Ontario; Hahnemann Medical College and Hospital, Chicago, 1893; aged 73; died September

Nature Planned

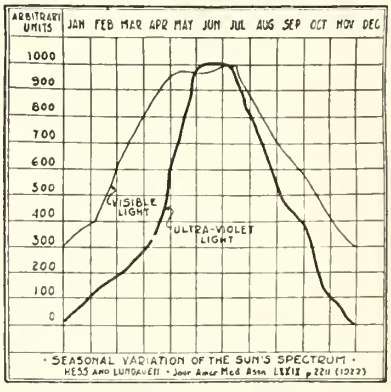
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5 following an extended illness. She was a native of Meigs County and had practiced for many years in Marion. Surviving are her husband and one sister.

John Adams Gardner, M.D., Ashville, N. C.; Starling Medical College, Columbus, 1880; aged 80; died August 20. Dr. Gardner was a native of Circleville and was for many years professor of anatomy and gynecology at Toledo Medical College. During the past 15 years he had devoted most of his time to cancer research. He is survived by one daughter, one brother, two half-sisters, one half-brother and one nephew, Dr. George R. Gardner, Ashville, Ohio.

Orin C. Standish, M.D., Orlando, Florida; Cleveland University of Medicine and Surgery, 1892; aged 65; died August 18. Dr. Standish was a native of Lyons, Ohio, and had pratciced medicine in Wauseon. He retired from the practice of medicine a number of years ago and entered the dry goods business. Surviving are his widow, one son, one brother and one sister.

Charles E. Williams, M.D., Ashland, Ky.; Southwestern Homeopathic Medical College and Hospital, Louisville, 1905; aged 58; Fellow of the American Medical Association; died October 5. Dr. Williams formerly practiced in Ironton, Ohio. He is survived by his widow.

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NEWS NOTES of OHIO

Toledo—Dr. John T. Murphy was elected president of the American Roentgen-Ray Society at the recent meeting of the organization in Detroit.

Bloomdale—Dr. R. E. Rasor has opened offices here for the practice of medicine and surgery.

Hamilton—Dr. John Borelli, until recently an intern at Mercy Hospital, here, has opened offices in Hamilton.

Brokensword—Dr. C. R. Sheckler recently celebrated his 50th anniversary as a practicing physician. He is the oldest physician in Crawford County in point of active service.

Upper Sandusky—Dr. C. F. Pope, graduate of Ohio State University, College of Medicine, has opened offices here.

Ashland—Dr. G. Delsher Fridline, who recently completed his internship at St. Luke's Hospital, Cleveland, has opened offices here in the rooms formerly occupied by his father, the late Dr. Jacob Fridline.

Zanesville—Dr. Daniel G. Caudy has opened offices here. Dr. Caudy is a graduate of Jefferson Medical College. He served his internship at Grant Hospital, Columbus, and for the past six years has been practicing in West Virginia.

Columbus—Dr. Lee H. Mann was robbed of $60 and his automobile by a man who called at his residence at night and asked Dr. Mann to accompany him on an "emergency" call.

Dayton—Dr. F. William Cox, for the past four years connected with the department of sur-

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gery at the Mayo Clinic, will return to Dayton, November 1, and become an associate of Dr. Robert C. Austin in the practice of diagnosis and general surgery.

Wellston—Dr. J. L. Frazier has resumed active practice after an extended illness.

Caledonia—Dr. H. A. Skidmore has announced his retirement from active practice because of ill health.

Marion—Dr. Fillmore Young has left for Vienna where he will spend the winter in post-graduate work in cardio-vascular diseases.

Akron—The Doctors' Symphony Orchestra, of which Dr. A. S. McCormick is director, has opened rehearsals for its seventh season. The personnel numbers 42 members of the medical and dental professions.

Sidney—A family dinner was given in honor of Dr. M. F. Hussey on his 76th birthday.

Madison—Announcement has been made of the marriage of Miss Margaret Johnson, Cleveland, and Dr. L. W. Judd, of Madison, formerly of Cleveland.

Painesville—Offices have been opened here by Dr. Mabel L. Pearce, formerly of Steubenville, and a graduate of the School of Medicine, Western Reserve University.

Cincinnati—Dr. Edward King is taking post-graduate work at clinics in Vienna and Munich.

Cleveland—Dr. and Mrs. Arthur J. Horesh have sailed for Europe where Dr. Horesh will engage in research work in nutrition at Heidelberg, Freibergh, Breslau and Kiel Universities. Dr. Hoersh was the recipient of a foreign Fellowship granted by the S.M.A. fund of the Babies' and Children's Hospital, Cleveland.

Dayton—Dr. Herbert L. Brumbaugh, formerly of the Department of Surgery, University of Michigan, and the Department of Orthopedic Surgery, University of Cincinnati, has opened offices at 670 Fidelity Medical Building, Dayton.

Middlefield—Announcement has been made of the marriage of Miss Florence Whittaker, Cleveland, and Dr. H. E. Shafer, Middlefield.

Uhrichsville—Dr. G. T. Haverfield described his recent trip through the Canadian Rockies to members of the local Kiwanis Club at a recent luncheon meeting.

A number of Ohio physicians took part in the program presented at the 42nd annual session of the Ohio Welfare Conference, held in Columbus, October 4 to 7. They were Dr. Carl Wilzbach, Cincinnati, chairman of the Health Section; Dr. Charles A. Neal, Cincinnati; Dr. H. L. Rockwood, Cleveland; Dr. C. H. Wells, Columbus, and Dr. William S. Keller, Cincinnati.

Physicians in Literature

The "Medicine Man" of the *Wayne County (Detroit) Medical Bulletin* has listed for the readers of that publication the following books (fiction) whose leading characters are doctors of medicine:

Doctor Serocold, by Helen Ashton.
Country Doctor, by Honore de Balzac.
Tree of Knowledge, by Pio Baroja.
Young Malcolm, by George Blake.
Dr. Glazebrook's Revenge, by Brown.
Roper's Row, by Warwick Deeping.
Memoirs of a Physician, Alexander Dumas.
Our Doctors, Maurice Duplay.
Dr. Grimshaw's Secret, by Nathaniel Hawthorne.
Country Doctor, by S. O. Jewett.
Doctor Breen's Practice, by W. D. Howells.
Seven Days' Darkness, by Gunnar Gunnarson.
Old Chester Stories, by Margaret Deland.
Village Doctor, by Sheila Kaye-Smith.
Island Within, by Ludwig Lewisohn.
Doctors' Wives, by Henry Lieferant.
Pierre and Jean, by Guy de Maupassant.
Ultima Thule, by Henry H. Richardson.
At the South Gate, by Grace Richmond.
Captain Blood, by Rafael Sabatini.
Dr. Graesler, by Arthur Schnitzler.
Dr. Krasinski's Secret, by Matthew P. Shiel.
Dr. Jekyll and Mr. Hyde, by R. L. Stevenson.
Alias Dr. Ely, by Lee Thayer.
Paterfamilas, by Wililam B. Trites.
A Doctor of the Old School, by Watson (Ian Maclaren).
Island of Dr. Moreau, by H. G. Wells.
My Brother Jonathan, by F. B. Young.
Dr. Pascal, by E. Zola.

Industrial Mishaps Analyzed

An interesting analysis of the 171,768 industrial accidents reported to the State Industrial Commission in 1931 from the standpoint of the nature of each injury has been completed by the Division of Safety and Hygiene, State Department of Industrial Relations.

Of the 171,768 cases, 43,201 showed injury to the fingers; 29,331 to the eyes; 23,831 to the trunk; 16,997 to the legs; 16,816 to the arms; 14,602 to the hands; 11,332 to the head and face; 10,155 to the feet and 5,503 to the toes.

The cases included 566 traumatic amputations; 10,851 burns and scalds; 33,369 crushes and bruises; 249 concussions; 60,176 cuts and lacerations; 15,395 puncture wounds; 11,172 fractures; 22,879 sprains and strains; 815 dislocations; 191 asphyxiations; 6 drownings, and 16,099 unclassified.

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Ohio State Medical Journal

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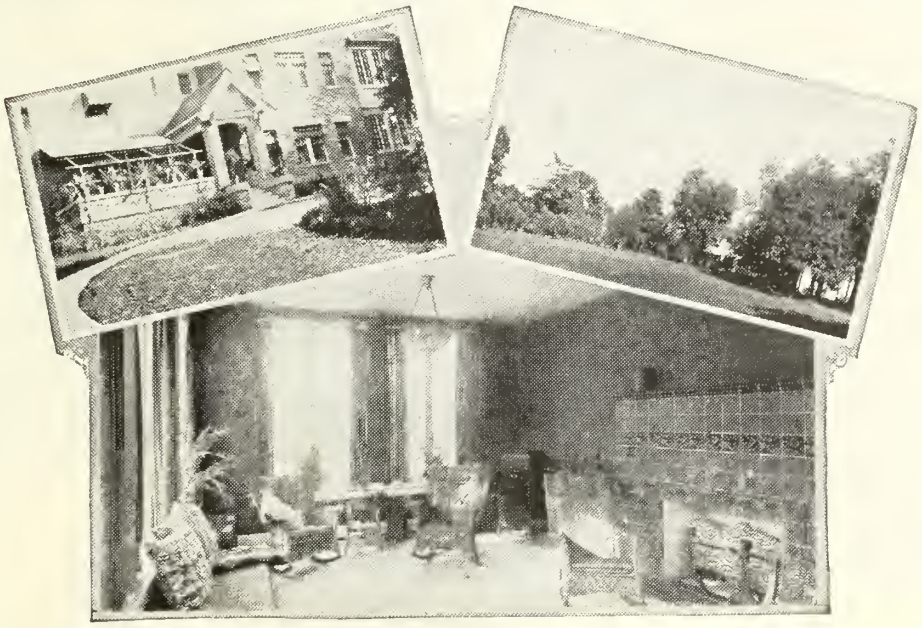
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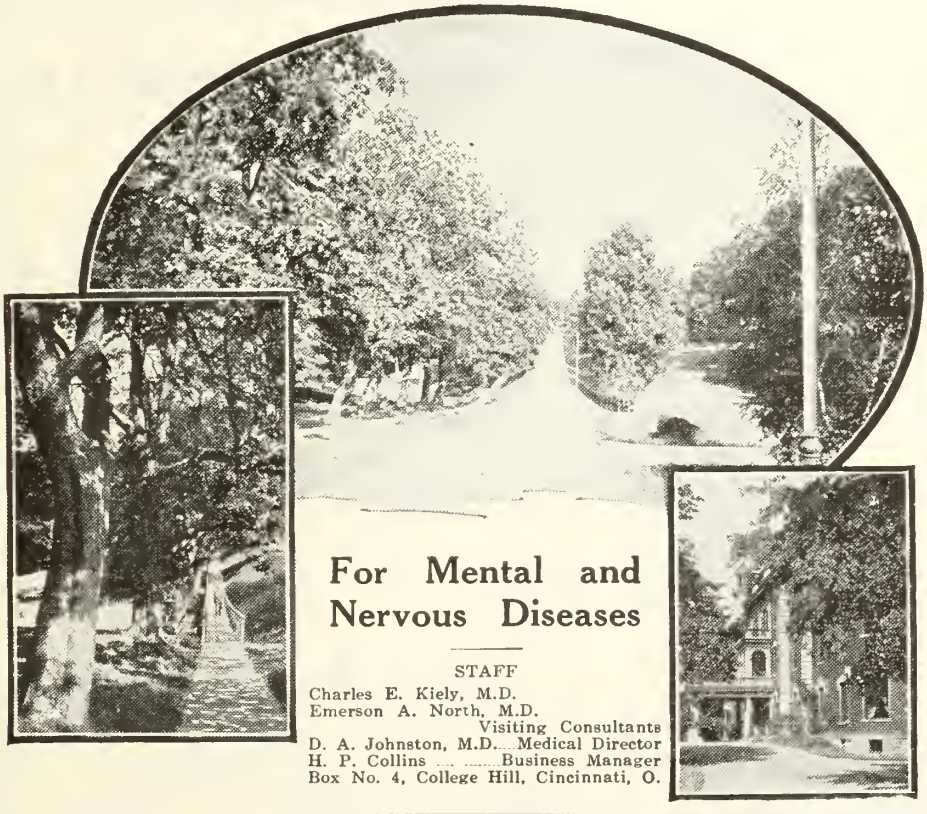
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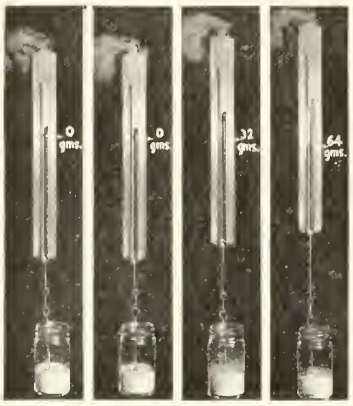
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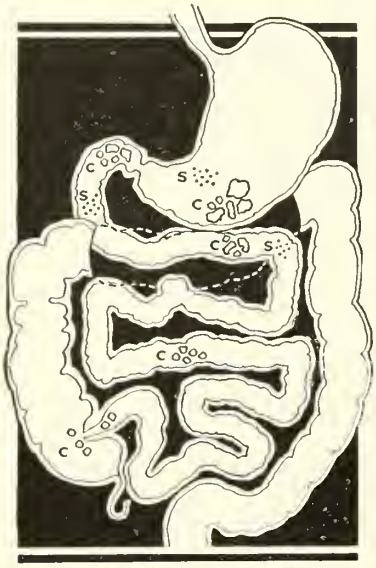
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[1] Morse and Talbot: Diseases of Nutrition and Infant Feeding, pg. 59.

[2] Marriott: Infant Nutrition, pg. 43.

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PUBLIC HEALTH - SOCIAL WELFARE MEDICAL ECONOMICS and ORGANIZATION PROBLEMS

With Editorial Comment by D.K.M.

As the New Year approaches, it becomes increasingly evident that the medical profession is gradually being forced into a position where it will have to make a decisive answer to some of the challenges publicly proclaimed by those who would revolutionize existing methods of medical practice.

Continuous Membership Really Vital

Medicine today is confronted with realities; with problems of unprecedented importance. It is face to face with the responsibility of choosing to wage a militant movement in defense of principles which it knows to be sound socially, economically and scientifically, or to peaceably acquiesce to the complete socialization of medical practice, which some have predicted is inevitable.

Judging from the record of the medical profession and the character of its personnel, we hazard the prediction that medicine will choose to fight when necessary. The challenges of its critics will be answered. Constructive policies will be evolved. Readjustments will be made by the profession in such a way that the fundamental principles underlying the present system will be safeguarded but programs which will meet the demands of social evolution developed.

What the ultimate outcome will be, none can predict.

However, one thing is certain.

Nothing can be or will be accomplished unless there is teamwork, sympathetic cooperation and group activity on the part of the entire medical profession, local, state and national.

Nothing which might be said could be more applicable to the situation now confronting the medical profession than the following comment made by a keen observer of present-day economic and social trends:

"In this world of modern business with its complexities no man can stand alone. The individual, no matter how strong as an individual, is weak without the strength of his group."

The futility of any attempt which might be made by physicians as individuals to cope with the serious questions involving medical practice is obvious. Individual effort alone has not raised medicine to its present heights. It will not bring it safely through the present crisis. The odds are too big.

Strong, united and active medical organization appears at the moment to be the one factor which may prove to be the salvation of the medical profession.

Admitting that the profession must stick together or fall individually, it is apparent, therefore, that medical organization now is facing its supreme test.

If given the proper impetus and support, medical organization can be made to function efficiently and effectively. There is no doubt about that. Its record proves as much. Medical organization remains or becomes as strong or as weak as the medical profession chooses to make it.

The inter-dependent relationship existing between the individual physician and his county, state and national medical organization is a reality which every physician should recognize. Neither can get far or accomplish much without the aid and support of the other.

Ohio physicians have earned the reputation as being unusually foresighted and progressive. This has been especially borne out by their firm belief in the value of organized effort. They have contributed liberally of their time and effort to the activities of organized medicine, local, state and national. The record indicates that individ- usually and collectively they have benefited from the organized activities which they have made possible and supported.

With a period of great uncertainty at hand, it is inconceivable that the physicians of Ohio would be unwise enough to permit medical organization to become static as a result of indifference or lack of support on their part.

If the same attitude of devotion, loyalty and cooperation which has been shown in the past is displayed by Ohio physicians to the cause of organized medicine in the future, progress can be made; new problems satisfactorily solved, and the position of medicine made more secure.

Upon organized medicine rests the hope of the medical profession. It must be mobilized to its greatest strength. To be effective its ranks must be free of those whom Merle Thorpe has aptly termed "mavericks—those who profit from the work of their organizations, yet who glibly disavow any interest in group endeavor; whose disinterest ranges from apathy to antipathy".

Poor Relief and Medical Charity

One of the signs indicating that some of the developments of the present economic crisis may ultimately bring about readjustments of permanent value is the manner in which many medical societies and academies of medicine have tackled in a concrete manner a few of the social and economic problems confronting the profession.

An example is the way a number of societies have acted to solve the question incidental to providing the needy sick with medical care and to smooth out chaotic conditions which have existed in this phase of public relief work for a long time.

For years the medical profession has given too little thought to the problem of medical charity. Those who were unable to pay were given service gratis by the private practitioner or referred to clinics which had been established to care for the indigent sick. The charity load, until recently, of both private physician and clinic was for the most part constant. It fluctuated little and in comparison to the present load was not a tremendous burden for either the physician or the clinic, generally speaking.

Now the situation has changed. Thousands who had been able to pay something for medical care are now destitute. Many persons formerly rated as pay-patients are without funds for necessary medical services. The physician must either care for these individuals as private charity patients or send them to some institution or clinic. The facilities of public clinics have been taxed to the limit; frequently overtaxed. Since most of the free clinics depend on the donated services of private practitioners, it apparently, on the surface, makes little difference to the physician financially whether he renders the service in his own office or at the clinic.

The whole situation is confusing and unsatisfactory, both for the medical profession and the public.

Some common methods of handling the problem of medical relief are fundamentally wrong for the reason that they fail to take into consideration the justice of providing the medical profession with reasonable compensation for the services it renders. A newer conception recognizes medicine and medical attendance along with shelter, fuel, food, clothing and the like as among the necessities of life. To date, however, little effort has been made to modify our present programs of relief to the poor.

The present unsettled state has focused considerable attention on this particular question. In some communities, the organized medical profession has presented the profession's side to official relief agencies. Due to the critical conditions now existing, little tangible success has been achieved. However, the ground work has been laid for revamping present relief methods following the emergency in such a way that the physician's predicament will not be ignored.

In some cities a central headquarters has been established jointly by the medical profession and various relief agencies, official and non-official, to control medical aid for the needy sick. All cases are investigated by the agency. If found worthy, the individual is referred to a private physician or permitted to select his own physician. Under the agreement, the physicians have consented to care for all cases coming to them through the bureau free of charge.

True, such a plan offers no relief for the financial load which the private practitioner is carrying. On the other hand, it has several points of merit which should not be overlooked.

First, it provides the private practitioner with the opportunity to keep his clientele intact; to continue to serve those who may be only temporarily financially embarrassed. It provides a safeguard in a way against encouraging clinic patronage. One of the fears advanced by some who have studied the situation is that large numbers who have been compelled to patronize clinics and institutions where free service is rendered may be permanently lost to the private physicians or that other serious disruptions in the close relationship which should exist between physician and patient may occur.

Second, the plan would assure the needy sick of better medical care, since it would eliminate serious objections which have been raised to institutionalized services generally.

Third, it might save the community a substantial sum, now being used to operate clinics with their capital outlay and overhead. In this connection, it may be assumed that many who have been imposing on free clinics would be removed from the charity classification and that the ensuing savings might enable the community to provide means of compensating physicians for the care of the deserving indigent sick.

Fourth, it would provide the nucleus for a centralized and well-organized community medical relief agency for normal, as well as abnormal periods, in which the medical profession would play a direct and responsible part.

Such a plan—now in operation in several localities—is not perfect. However, it may be a step toward the solution of a serious problem.

If the medical profession can succeed in maintaining its contact with the public through the medium of private practice; in minimizing the necessity for more and larger clinics, and in strengthening its position in community relief activities, it will have accomplished something, at least. At any rate, the plan described offers food for thought. It may be a partial solution for a number of important problems.

Title of "M.D." Rather Than "Dr."

In keeping with the American mania for going to extremes is the numerical increase in recent years of persons of various vocations who have seen fit to use the prefix "Doctor" to their names.

The public recognition which has been accorded to some 57 varieties, more or less, of doctors is amusing, if not ridiculous. We have doctors of this and doctors of that. Some of them never saw the inside of a college. Some of them couldn't even give a comprehensive answer as to the meaning of the term "doctor". No wonder the public is confused. No wonder the term no longer carries the dignity and prestige it once carried.

Far be it from the thoughts of the medical profession to believe it has a claim to a monopoly on the use of the title. However, it does seem as if something should be done, in all fairness to those who have actually earned the right to use the term, to distinguish between the person who has extensive academic training and knowledge and the one whose scholastic training, in many instances, fails to exceed the preparation given the average high school graduate.

How to solve the problem is itself a riddle. Maybe it's foolish to even consider it. However, the suggestion recently made in *The Bulletin of the Wayne County (Detroit) Medical Society* as to how the medical profession should regard the question sounds sensible and if put into practice might have some beneficial effects.

Commenting editorially on the subject, our Detroit contemporary said:

"The term 'doctor' is so widely applied that a diminishing dignity and prestige seems to reward those who affix it to their names. So common has the title become that those who have a proper right to it are finding it necessary to use their academic degrees to avoid confusion.

"Webster defines the word 'doctor' as '(1) a teacher, one skilled in a profession, or branch of knowledge; a learned man; (2) an academic title, originally implying that a possessor of it is so well versed in a department of knowledge as to be qualified to teach; (3) one duly licensed to practice medicine; a member of the medical profession; a physician; a surgeon; (4) a repairer of anything.'

"The last is a colloquialism that by careless usage has grown to rival and even obscure the correct definition. Today 'doctors' repair shoes, rub spines, sell eyeglasses, train prize fighters, comfort souls, treat corns or convert milady into a thing of wondrous beauty. Rare indeed is the gathering of even small size that does not sport at least one individual who answers to the title of 'doc.' It makes little difference whether he's a D.C., D.O., D.Ch. or a D.F., he's a doctor and the world, though ofttimes reluctantly, accords him respect.

"Those of us who have full claim to the academic title modestly suppress our discomfiture at being classed with 'repairers of anything' hoping the while that certain obvious differences will sooner or later assert themselves to set matters right. It appears, however, that this hope is not soon to be realized since the public is becoming more and more confused by an increasing host of false claimants to the title.

"It has become necessary, therefore, for those who, by dint of many years of hard work, have earned the right to be called doctor, to shed some of their modesty and resort to the use of the full academic degree whenever the occasion demands.

"In the case of physicians, M.D. should be used after the name on professional cards and signs and on scientific papers as a designation that the writer possesses a medical degree and is something more than a 'repairer of anything.'"

Beware of Racketeers

These are dangerous times for the credulous and gullible, and for those who are willing to let themselves become involved in half-baked ventures on the pretext that they are short-cuts to a satisfactory solution of major problems which have accompanied the lingering economic crisis.

Recent investigations in the field of medicine indicate that some physicians have proved susceptible to the influences of those who have undertaken to promote unsound and dangerous schemes of marketing medical service.

Exposés published in recent weeks in *The Journal of the American Medical Association* divulge a type of racketeering in the distribution of medical service which, if permitted to grow, will undermine the foundation of our existing system of medical practice.

The ramifications of some of these new commercial ventures in the field of medicine are too numerous and complicated for review or analysis at this time. However, the fact that they have been conclusively proved to be dangerous by those who have thoroughly investigated them should be sufficient to place every physician on his guard if he cares anything at all about the future of his profession and his own economic independence.

The point which the physician should take into consideration at this time was well stated by the editor of the *West Virginia Medical Journal* recently when he said:

"The physician who feels that he might be interested in some new form of practice should ask himself three questions. First, does the new plan place the control of medical practice in lay hands? Second, does the physician work on a salary for a corporation or group organized for profit? Third, does the plan advertise for patients or solicit patients in any way. Unless all three of these questions can be answered in the negative in regard to any new form of medical practice, we feel that it should be given a wide berth."

In all probability there will always be a few members of the profession who, as the editor of the *A.M.A. Journal* declares, "will be willing to

sell their medical birthrights for the promoters' mess of pottage". The great bulk of the physicians of the country will never knowingly fall for the ballyhoo of the medical racketeer. Nevertheless, even the honest and ethical practitioner must remain constantly on guard, lest he be enticed by subterfuge into lending his good name and services to devices which prostitute the field of medicine to the detriment of the public, as well as the medical profession.

Especially now when his income from practice has been materially reduced and frequently the future is gloomy, the physician should make certain that a sort of mental panic does not overtake him and distort careful planning and clear thinking. He should remember that many of the schemes now being promoted to lift his financial stress are but bubbles which are destined to burst with dangerous, perhaps fatal, results at a later date. Nothing should prove acceptable as something new in medical practice unless it can be conclusively shown to be fundamentally sound and something which will ultimately prove of lasting benefit.



Veterans' Policy Change Imminent

In a radio address on October 26, Brigadier General Frank T. Hines, Administrator of Veterans' Affairs, presented an illuminating review of the veterans' relief activities of the Federal Government.

In closing his talk, General Hines expressed the belief that a modification of the present governmental policy with regard to ex-service men and in the administration of the World War Veterans' Act is needed—in fact, imperative.

General Hines said:

"It is quite evident from the viewpoint of a national policy and a balanced budget that the veterans' relief program merits the most careful consideration of the legislative and executive branches of the Government. It is thought that the time is propitious for extensive review and study of the program of veterans' relief in the light of past experience and future expectations.

"As a result of such a study a national policy of veterans' relief should be adopted to be applied to survivors of past wars and their dependents, and to veterans of any future wars in which our country may be involved which shall reflect a fitting and liberal recognition of the Government's moral obligation to those who have served, while at the same time having due regard to the cost such a policy will impose upon our citizens.

"A sound national policy dealing with all ex-members of the military forces of the country must rest upon the foundation of the character of military service, equality in benefits to veterans of all wars, consideration of the degree of disability sustained by each of them and their financial need for Government aid.

"Military service to one's country cannot be evaluated in terms of dollars and cents. Gratitude to those who have so served their country cannot be expressed under any such policy we might adopt, but we can devise a system of veterans' relief which will assure that benefits are granted equally to those who are entitled to them and in need of them.

"It is the purpose of the Veterans' Administration before the Joint House and Senate Committee to make specific recommendations as to a national policy which should be adopted and it is our firm conviction that a policy will be evolved by the next Congress or by a succeeding Congress which will have evaluated all of the factors involved in this great problem and will result in a system equitable to all concerned."

General Hines' comments are significant in that they are concurrent with the increasing sentiment toward a badly needed change in policy concerning the veterans' question. None realizes better than members of the medical profession the necessity for a change in the Government's policy and procedure in the veterans' program.

As pointed out by General Hines, the executive and legislative branches of the Government are already studying the existing situation. However, something more than conferences in official circles is needed. Public sentiment for changes which will place the veterans' program on a sounder and equitable basis must be further crystallized. Such a movement is already gaining momentum. It promises to accomplish much in the interests of deserving ex-service men and the nation as a whole. It is a move in the right direction and deserves the careful consideration and support of all who see the dangers of the present system.

The medical profession with its information and knowledge of factors involved in the existing program is in a position to be of material aid to those endeavoring to reach a satisfactory solution of this outstanding question. It is an opportunity which the medical profession cannot afford to overlook. The medical profession has a right to be heard in conferences preliminary to changes in the veterans' program, especially when medical questions are involved. Unless, of course, the profession, through medical organization, is prepared to meet the issue and makes a concerted demand that it be given a voice in the matter, its part in the whole affair will be minor and of little consequence. The united and enthusiastic support of all physicians must be forthcoming if the steps which are being taken to present the medical profession's views on the question are to be effective.

Angina Pectoris

JOHN P. ANDERSON, M.D., Cleveland, Ohio

MORE than 160 years ago at a lecture before the Royal College of Physicians in London, William Heberden outlined a symptom complex so definite that it has since been regarded as a disease. He called this Angina (angire to strangle) Pectoris and his original description was very expressive.

"Those who are afflicted with it are seized while walking and more particularly when walking soon after eating, with a painful and most disagreeable sensation in the breast which seems as if it would take their life away if it were to increase or continue. The moment they stand still all the uneasiness vanishes."

He called attention to the substernal location and brachial radiation of the pain, the absence of dyspnoea and the tendency to sudden death. The pain is usually in the middle substernal region. The patient experiences a sensation of crushing as though the chest were in a vise. The usual radiation of pain is to the left shoulder and down the inner part of the left arm to the elbow or even to the ring and little finger. Less frequent radiations of the pain are to the right arm, the head, neck, lower jaw and teeth, to the interscapular region and to the epigastrium.

When the primary pain is located in the usual place, i.e., the substernal area, and when there is a secondary radiation to other areas even though of unusual location cases of angina are not very difficult to recognize. But when the primary pain is in an unusual location, diagnosis may be quite difficult.

I have seen several patients who have had their teeth extracted because of angina, and one patient because of a tight feeling in her throat had visited several otolaryngologists during a period of two and a half years. She finally presented herself for an examination thinking that an inward goiter might be responsible for her symptoms.

Another patient had a severe pain in the right shoulder so that he finally found his way to an orthopedist. On direct questioning most of these patients admitted some pain in the substernal region with severe attacks, but in their minds this was so much less important than the other symptoms that they had never mentioned it to any physicians they had seen before.

Rarely does a physician see a patient during an attack of angina, consequently the diagnosis must depend on the history. It is important to get an accurate description, keeping in mind that it may be necessary to ask leading questions. If these atypical attacks are not recognized, the patients are likely to be considered as neurotics, and urged to disregard their ailment. This increases the seriousness of the condition considerably.

The attacks usually are induced by physical effort and the first attack may follow some unusual or unaccustomed exertion. For instance, a man in his sixth decade may walk to the top of a high monument, or a business man may decide that he isn't getting enough exercise and may start to walk to work, or a former athlete may try to live up to his past reputation. On the other hand, the attacks may occur or start during the night.

About 50 per cent of the patients have a normal blood pressure and in only about 25 per cent is essential hypertension present. There is seldom any important change in blood pressure during attacks.

The pulse and heart rhythm usually are regular. Extrasystoles may be present, but other irregularities are very uncommon. One sees an occasional instance of associated paroxysmal or even continuous auricular fibrillation and the same is true of paroxysmal tachycardia and flutter.

Breathing is difficult sometimes on account of the splinting in the chest muscles in an attempt to keep the entire body motionless, but there is never any respiratory spasm, as in asthma, nor any true dyspnoea or cyanosis.

Of 100 consecutive patients, 6 per cent were in the third decade, 24 per cent the fourth, 33 per cent the fifth, 34 per cent the sixth, and 3 per cent in the seventh decade of life when the angina started. Two patients were more than 80 years of age but their trouble had been present for a good many years.

Men are affected more often than women (80 per cent men and 20 per cent women), and persons in responsible positions seem more susceptible. Formerly it was reported mostly in private practice, but with the increased use of machinery and the responsibility entailed in operating it, I believe angina is becoming more frequent among workmen.

The most important part of the investigation is an accurate history, as the physical examination may be normal to all methods of examination including inspection, palpation, percussion, auscultation, blood pressure determinations, roentgen-ray study and electrocardiography.

In my series, 25 per cent of the patients, including those that had only slight accentuation of the aortic second sound, showed a normal heart. The other 75 per cent gave evidence of some abnormality, such as moderate cardiac enlargement, systolic murmurs at apical or aortic areas,

Read before the Medical Section, Ohio State Medical Association, at the 86th Annual Meeting, Dayton, May 3 and 4, 1932.

arterial hypertension or abnormal electrocardiograms. A rather common finding is a much accentuated aortic second sound.

The electrocardiograms usually show some left ventricular preponderance and may show slurring of the S-T intervals but more serious findings such as inverted T-waves in the first and second derivations or delayed ventricular conduction or partial heart block or branched bundle block indicate myocardial damage from coronary occlusion.

A rather striking feature of the examination is the infrequence of disturbed rhythm or congestive failure. Sometimes the anginal attacks disappear with onset either of auricular fibrillation or of congestive failure, to recur when normal rhythm or compensation again are established.

DIFFERENTIAL DIAGNOSIS

Cardiac neuralgia or intercostal neuralgia is quite common in nervous women. The pain is submammary rather than substernal, and bears no relation to effort, though it does seem to be associated with loss of sleep and fatigue. It occurs in men less frequently than in women, but excessive smoking may induce it. This is often referred to as pseudo angina, but I think this term is unfortunate as it may cause patients much unnecessary worry.

Coronary thrombosis may occur in patients who have never had angina or in those who have had angina for a long time. It is similar to an anginal attack but more severe, is not relieved by nitrites and requires morphine. The blood pressure falls, the pulse is weak and may be irregular. The patients are more completely prostrated and the attack lasts for hours or days. They develop fever, leucocytosis and possibly a pericardial friction rub or signs of congestive failure. An electrocardiogram usually shows some abnormality.

In making a diagnosis of angina, gall stones or cholecystitis, gastric or duodenal ulcer, and also acute gastritis must be considered.

Myositis, pleurodynia, herpes zoster and mediastinitis are other conditions which occasionally enter into consideration in a differential diagnosis.

When angina was first recognized as a clinical entity, it was felt that poor coronary circulation probably had something to do with it. Then appeared autopsy reports on patients who had died with angina and whose coronary arteries showed no sclerosis. Singer also found in experimental animals that he could block the coronary vessels with lycopodium powder or clamp off a coronary artery and get no registration of pain. Accordingly a number of other theories have been offered to explain angina.

In 1923 MacWilliam and Webster reported on the sensory phenomena associated with defective blood supply to working muscles, and they found that when the blood supply to the arm is shut off by constriction pain was not caused, even after 20 minutes, provided the muscles remained quiet. When, however, the ischaemic arm was made to contract, fatigue was brought on much more quickly than in the normal arm and at the fatigue point there was severe pain. Moreover, pain could be elicited even before the fatigue point was reached, at a time when the contractile power of the muscles was still good. As soon as the constriction was removed and circulation was renewed the pain promptly disappeared. If the arm were exercised so that it was partially fatigued before the constriction was applied, then pain was induced with a lessened amount of exercise. The authors suggested that anginal pain may be caused similarly.

Sir Thomas Lewis in his St. Cyres lecture in 1931 again mentioned these experiments and suggested the analogy to cardiac pain. He suggested that there appears to be a local accumulation of some product capable of irritating the nerves and as soon as there is either fresh circulation or cessation of muscle activity the pain subsides.

MacWilliams also found experimentally that animal hearts were much more likely to undergo ventricular fibrillation if they were rendered susceptible by a poor blood supply and Resnick pointed out the marked tendency to development of ventricular fibrillation when dogs were subjected to breathing mixtures of low oxygen tension.

Wearn has shown that there is a very rich capillary circulation in the heart, amounting to approximately one capillary per muscle fiber in cross section, and he has also pointed out that the Thebesian veins have a rich anastamosis with the coronary veins, capillaries, and perhaps also the arteries.

He referred to two instances where both coronary arteries were completely obliterated at their orifices and yet the patients had been able to work and earn their own living, the only circulation available being through the Thebesian veins.

It would seem reasonable to suppose then that if there is an area of heart muscle receiving an inadequate blood supply through the coronary circulation that an anastomotic circulation may be reestablished if time is allowed. Such would seem to be the plausible explanation in those patients having remissions from anginal pain.

TREATMENT

During an anginal attack, patients almost invariably are forced to rest and that implies standing still where they are. They are not able to go and look for a comfortable place to lie down. Patients often have told me that they feel that if they don't stop immediately something serious is sure to happen. So the enforced rest is partly from fear of consequences and not entirely because of the pain. I think it is very important for patients to stop as soon as they begin to feel

the pain. Not to do so increases the severity and length of attacks and adds considerably to the danger.

During attacks nitroglycerin grains 1/100 dissolved under the tongue or inhalation of an amyl nitrite pearl should be administered promptly. This almost invariably relieves the attack and morphine rarely is necessary. When morphine is required, coronary thrombosis always should be suspected and the patient should be treated accordingly.

After the attack, patients usually insist upon knowing what it was and I believe it is best not to evade the issue. The patient knows that the condition is real and also senses that it is serious, so he is not frightened any more by the truth. I believe too, that such terms as pseudo and false angina should be avoided. The patient will have subsequent attacks and the condition should be discussed with him thoroughly so that he may know how to meet the attacks, or to avoid them.

Patients with angina should be cautioned to avoid sudden effort, especially after meals, on a cold day or when excited. Smoking should be discontinued but sometimes it is preferable to allow a few cigarettes or a mild cigar daily, if total abstinence is likely to add to the patient's nervousness. All smoking should be done while the patient is at rest.

Persons with high-strung active temperaments should try to adopt a calm, equable mode of living, to plan their work carefully and to do it without undue effort or excitement. A daily sedative may help.

It is important to give patients something to take during attacks. This has a dual purpose, as it helps to relieve the symptoms and also gives a sense of security in having something to use if necessary. I prefer nitroglycerin for this purpose as it is more convenient to take than amyl nitrite pearls. The tablets of nitroglycerin should be renewed occasionally if not used. I believe also that there is some advantage in giving vasodilators routinely between attacks and for this nitroglycerin may be used two or three times daily, or sodium nitrite, 1 grain, alone or in combination with some sedative.

Of the purin derivatives one might mention theobromine sodium salicylate (diuritin) theophyllin, ethylene diamine (metaphyllin).

Small doses of alcohol are beneficial, but one should be very careful in advising an habituating drug in a condition such as angina. Very large doses should be strictly discouraged.

Digitalis is of little use except when signs of congestive failure are present.

When lues is the causative factor, appropriate antileutic treatment should be given, the use of the arsenicals, depending on whether there has been congestive failure. One should keep in mind that occasionally lues is present even with a negative blood and spinal fluid Wassermann. In one such case treated recently, remarkable improvement resulted from antiluetic treatment with a return of the blood pressure to normal and with complete disappearance of anginal attacks.

All unnecessary operations should be avoided and necessary ones should be followed by a longer convalescence than usual. When hyperthyroidism is present, thyroidectomy often relieves the anginal attacks. Obesity is a disadvantage and all obese patients with angina should be advised to reduce gradually. Definite focal infections may throw an added burden on the circulation and should be removed, but questionable foci should be left alone. Surgical operations for the relief of angina, such as cervical sympathectomy have not produced as good results as were anticipated. Paravertebral alcoholic injections are simpler and give fairly satisfactory results. Unfortunately, they also may be followed by much local hyperesthesia, but this passes after a few weeks.

Roentgen-ray treatments over the cervical and dorsal sympathetic system seems to give relief in some instances, with no ill effects; hence, I believe they are well worth trying.

HOW SERIOUS IS ANGINA?

One of the most puzzling facts about angina is that some patients are able to carry on for many years, and may even die from some other cause, while others die suddenly in the prime of life. I will cite a few illustrative cases.

A stationary engineer, aged 51, was seen in January, 1924. Since 1916, on exertion he had been having daily attacks of pain in the substernal region, radiating down each arm as far as the elbows. He had had some pain in the legs but that was never severe. For several years he usually had had several attacks each day and had been using nitroglycerin tablets frequently in doses of 1/25 grain. One night while returning from work two negroes jumped on him and tried to steal his watch. He was able to beat them off and to continue home without an attack.

On examination his heart was enlarged to the right and to the left, but there were no murmurs or signs of failure, and his pulse and blood pressure were normal, (pulse 72, blood pressure 120/85). His electrocardiogram revealed nothing abnormal. This man is alive and active at the age of sixty.

A woman, aged 72, had had anginal attacks for a year in 1911, with complete remission of symptoms until 1926, since which time she has had them frequently. When seen in 1929 the exertion of walking just one block was sufficient to precipitate the anginal attack.

On examination her heart was normal in size, regular in rhythm, and no cardiac murmurs were perceptible. The palpable arteries were very little thickened, though the aortic second sound was accentuated. The pulse rate was 60, and the blood pressure 120/80. There was moderate congestive failure as evidenced by râles at the lung bases, some enlargement of the liver, and edema of the legs. Her electrocardiogram showed an inverted T-wave in derivation I. This patient also had a myxedema with a basal metabolic rate 40 per cent below normal and a secondary anemia

with an erythrocyte count of 3,800,000 and hemoglobin only 68 per cent.

A patient aged 40 was seen December, 1929. He had been having substernal pain with effort for six weeks, but finally the pain had begun to appear while he was at rest. He appeared healthy. His pulse rate was 82, and the blood pressure was 138/82. The heart was normal in size and rhythm, and with no murmurs or signs of failure. An electrocardiogram was normal with an inverted T-wave in lead III. The Wassermann test gave negative findings. I advised him to take several weeks' complete rest but another consultant told him there was no angina and no organic heart trouble and that he could safely lead a normal life. On the strength of that he obtained a large amount of insurance and died suddenly less than two months later.

A patient aged 58 had been having anginal attacks with effort for three and one-half years; finally these occurred with but little effort. He was a very nervous person, and sometimes would have attacks during ordinary conversation. His blood pressure was normal and cardiac examination revealed nothing significant, but I felt that his condition was serious and advised a complete rest. He asked if I thought it would be satisfactory if he went to one of the mineral baths and I approved this plan provided he would go for a rest and would not take any of the hot baths. This advice the patient failed to follow and he died during his first hot bath.

I don't think the seriousness of the case necessarily depends on the severity of the attacks, as one patient will have quite severe attacks for years and another who has a few mild attacks may die suddenly. I think the amount of effort possible before attacks are precipitated is far more important, and I always feel that any patient who has attacks while at rest is in very serious condition.

The blood pressure seems to have little to do with the prognosis so far as sudden death with angina is concerned. A moderately increased pressure may even be advantageous though malignant hypertension, of course, increases the gravity of the condition.

Cardiac murmurs may be only an indication of sclerosis of the heart valves and do not necessarily affect the prognosis, but murmurs that are attributable to hypertrophy and dilation of the heart are unfavorable.

Occasional extrasystoles arising from one focus in the heart are relatively unimportant, but extrasystoles arising from multiple foci are an evidence of rather widespread myocardial damage. The presence of this condition can only be determined by the electrocardiograph.

Any patient with an abnormal electrocardiogram such as delayed auricular or ventricular conduction, branched bundle block or abnormal T-waves, has a more serious prognosis. A previous history of coronary thrombosis is also very serious.

Anginal patients with aortic regurgitation of luetic origin have a very poor prognosis, but luetic patients having angina without aortic regurgitation, often get along very well with appropriate treatment.

I have felt that anginal patients under 45 years of age and especially those under 40 have a poor prognosis. This is partly because they are more active and find it very hard to cut down their work and still carry on.

The average duration of life after the onset of attacks is about five years, including those patients who die suddenly during the first few attacks.

I believe many of these early deaths could be avoided if people would have periodic health examinations, and were cautioned against attempting too strenuous effort suddenly, and if patients having anginal attacks during rest or with little exercise would take long periods of complete rest.

A great deal can be done for anginal patients by recognizing their condition and talking it over with them frankly. They must learn about how much physical effort they can stand and must live accordingly. All attacks, no matter how mild, should be respected. These patients still can do a great deal of work, but it should be done without hurry or undue excitement. When angina is recognized promptly and when the patients follow instructions, I believe the outlook is much better than we have been led to believe in the past.

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DISCUSSION

S. MORGENROTH, M.D., Akron: My discussion of this paper will of necessity be brief as Dr. Anderson has practically exhausted the subject. The title could well be interpreted—"What is the prognosis in Angina Pectoris"?

We call a certain syndrome of symptoms angina pectoris and as disease of any one structure cannot explain all cases, having thus a varied etiology, it is largely on this that we evaluate the seriousness; also explaining why some die after one or two attacks, others living for years.

Those having syphilis, marked arteriosclerosis, poor heart sounds or congestive failure are unfavorable cases and the more of these factors present the worse the prognosis.

D. C. Sutton has recently stated that when there is little change in the electrocardiogram and the patient responds to theocalcin or euphyllin a hopeful prognosis may be given. If no response,

even though the nitrites relieve, the prognosis is hopeless.

As to treatment, Dr. Anderson has well covered the field of therapeutics, but I would like to say that in the use of morphine for the relief of attacks of true angina, Brooks states he has never seen addiction to the drug and that has been my experience. Also that the sublingual use of nitroglycerin gives no better results than when swallowed.

The use of roentgen rays over the dorsal and cervical sympathetic system, as first suggested by Groedel, with a report of sixteen cases—six with complete relief and five improved—appeals to me far more than cervical sympathectomy or paravertebral alcoholic injections.

Although the heart is the location of the attack, the nervous system is the source of the "anginous state" and if we treat this by rest of mind and body much can be done in the way of prevention and a real cure.

STANLEY C. SCHILLER, M.D., Mansfield, Ohio: It has been a privilege to hear Dr. Andersons' interesting presentation of angina pectoris. In view of the mass of conflicting opinion and theories advanced in explanation of the origin and various manifestations of this protean symptom-complex, Dr. Anderson is to be congratulated in keeping his views practical.

That such a wide divergence exists between the various clinical manifestations and the pathological findings at necropsy is not to be wondered at if we would perhaps reflect that in addition to this highly vascular neuromuscular organ, the anatomy of which is not precisely known and the physiology but poorly understood, we are dealing with a variable personality factor: Consequently in our attempt to explain angina pectoris on a basis of pathology cannot help but result in chaos, excepting of course the several clearly defined and recognized pathological processes such as coronary thrombosis, acute aortitis (syphilitic and rheumatic) and certain tachycardias.

As the findings of Dr. Anderson suggest, evidence of arteriosclerosis is a most frequent finding, and by his series the incidence of angina is far greater in the fifth and sixth decades of life. I wonder that in our effort in searching for specific and extrinsic disease factors as a cause for all disordered function of tissue we are not prone to devaluate the part played by the degenerative involutional process of age which histologically is an atherofibrosis of the vessel walls in no wise differing from that found in coronary disease and in which we are inclined to attribute to the various past infections of life, overwork, overeating, alcohol, tobacco, emotional strain, etc. Is it not reasonable to consider some cases of arteriosclerosis, which affection we must remember is not always general, as an intrinsic involutional process inherent in the organism, and that this functional interference of coronary flow is but a localized incident in the fulfillment of a biologic death characteristic of our species?

According to the anoxemia or ischemic theory as mentioned by Dr. Anderson it is evident that a normal heart under conditions of extreme exertion may fail to receive sufficient blood of normal quality through normal coronary arteries, with resulting anginoid distress. Sutton and Lueth have observed that these choking sensations or actual precordial pain experiences were analogous to the sensations of athletes just before "getting their second wind". In patients suffering from angina pectoris there exists a surprising similarity between the sensation of an extreme effort in youth and their present sensations during an attack of angina of effort. Thus under normal physiological conditions the coronary arteries are able to respond adequately up to the point of extreme exertion or "second wind" when extra compensatory factors enter in. But in the patient with angina pectoris the coronary dilator mechanism fails to operate.

In view of the evidence offered by Gross as to the pronounced tendency towards increased vascularization of the heart muscle in the middle and later years of life, and the universal acceptance of a better prognosis in young and very old patients with angina pectoris it has seemed rational to institute measures to further develop or encourage the development of new coronary branches by the use of graded exercises. It remains unnecessary to say that this procedure should be used only in selected cases and with reasonable caution. Thayer uses the setting-up exercises of the U. S. Army General Hospital No. 9 which he has modified to apply to individual requirements. It is the opinion of Conner that some method such as these exercises to develop the anastomotic circulation in the diseased coronaries, furnishes an encouragement toward the solution to this problem—if it is ever to be solved. In consideration of the very convincing evidence submitted by Wearn of the possible communication of the Thebesian vessels through the capillary bed with the terminal arterioles of the coronary system—nature provides a remarkable compensatory mechanism to maintain a functioning organ. Our conclusions from these observations would lead us to believe that the laborer or one engaging in a life-long moderate degree of exercise would develop a more free anastomosis of his coronary arteries than one engaging in more sedentary habits; and further that the brain worker becomes potentially a more probable candidate for occlusion and angina by virtue of his physical inactivity rather than the mental stress incident to his business affiliations.

Why are not all cardio-aortic affections painful? Herrick say that his experience with cases of acute thrombosis of the coronary artery seems to strengthen the view that the paroxysm of angina of effort has its origin in a perversion of function of the coronary artery or the muscle supplied by that artery or both. Kohn states that we must not forget that the anatomical lesion is not the disease, rather the resulting disturbance of function and the reaction changes in the organism. Could we venture to say then that angina could be a functional phenomenon of spasm analagous to the production of hypertension by spasm of the arterioles and nervous indigestion by spasm of the digestive tract and intermittent claudication by spasm of the arteries of the extremities?

Libman noted the variation in reaction of the hyposensitive individual and advanced his "substitution symptoms" in explanation of varying pain equivalents. Houston of Georgia introduced the term of "spasmogenic aptitude" and used it to explain this incidence of anginal pain in which the underlying pathology may be grave, slight, or none at all. If in an individual the spasmogenic aptitude is great a slight stimulus of neurogenic nature will suffice to evoke the spasm with its characteristic pain; while if the spasmogenic aptitude is absent the utmost stimulus will fail to evoke the spasm. The degree of spasm is always in direct ratio between the spasmogenic aptitude and the vigor of the stimulus. This tendency is not confined solely to cardiac muscle but to all

unstriped muscle in the different systems. In China this spasmogenic aptitude does not exist which may explain the absence of angina among the Chinese people who otherwise present the usual types of heart disease as seen in this country. Roberts of Atlanta adopts this term and brings to our attention the personality of the southern negro in whom he states that apart from luetic aortitis he had not seen a case of anginal pain among this race. He further states that while the pure southern negro has a well developed susceptibility and sensitivity to pain they seem to be less highly organized nervously and consequently unadapted in ability to "worry unpleasantly". To quote Roberts: "We call a syndrome essential angina pectoris or essential hypertension, or nervous indigestion, but in reality it can be explained on the basis of the spasm of muscle in different systems dependent not primarily upon an organic or cellular pathology of that system but rather upon the spasmodic aptitude and constitution of the individual. The phychology of stress, strain and struggle in the white races is in sharp contrast to the humorous carelessness of the musical negro or the placid acceptance of the gentle Chinaman".

In the final analysis of this complex problem it may be that it is only the penalty that we the possessors of a complex and highly organized central nervous system, are paying for having attained the highest stage of developmental progress in the evolutionary scale; and when the mysteries of the autonomic system with its two opposing components are better understood, perhaps then will the mechanism of anginal pain be better understood.

Surgery of the Sympathetic Nervous System*

M. M. ZINNINGER, A.B., M.D., Cincinnati, Ohio

KNOWLEDGE of the sympathetic nervous system has been taught us for many years by anatomists and physiologists, but with a few notable exceptions it did not come to the consciousness of clinicians until in the past decade. During these early years the physiologists had been studying rather intensively the action of this division of the nervous system in animals, and the contributions of Gaskell, Langley, Starling and Bayliss, to mention only a few, are well known. However, the application of the information thus obtained was not confirmed for man, nor did the clinical applications in certain human diseases seem to occur to any except a few. Credit for the first clinical application seems to be due to Bodard who suggested sympathectomy for exophthalmic goitre in 1876, but not until 20 years later in 1896 did Jaboulay do the first planned cervical sympathectomy for that condition. Francois Franck in 1899 suggested this same operation for angina pectoris, but the first application of the operation for this condition was not until 1916 by Jonesco. The next important contribution was apparently that of Leriche, who, in 1921, reported the results of an operative procedure, called by him periarterial sympathectomy, and which he had performed in about 70 cases of causalgia, painful amputation stump, trophic ulceration, and other vascular lesions of the extremities.

Again interest lagged until Royle and Hunter in 1924 advocated the division of the gray lumbar rami, an operation they called ramisection, in certain types of spastic paraplegia. They noted in patients on whom this operation had been performed that in addition to relief of spasticity there was increased temperature of the extremities, apparently due to vasodilatation. Also, if chronic constipation had been present before operation there was a marked improvement in this condition. These observations soon led others to further investigate these findings and to apply them clinically to cases of abnormal function of the gastro-intestinal tract and vascular diseases of the extremities. The focus of the profession once on these applications, rapid progress was made in investigation of ways, means and results, and a tremendous literature has accumulated.

A brief review of the development and anatomy of the sympathetic system would not be amiss before any further discussion is attempted. Embryologically this system is related to the central nervous system through the neurocyte,—the undifferentiated cells composing the primitive neural tube. Certain of these cells, after differentiating into so-called neuroblasts, migrate ventrally from the neural tube to form the sympathetic chain and ganglia and also the chromaffin tissue. This latter tissue is made up of cells with a strong affinity for chrome salts and is located principally in the medulla of the adrenals, in the carotid, aortic and coccygeal glands and in the so-called Gelben zellen of the gastro-intestinal tract. At any stage in this embryologic schema, tumors may arise known successively as neurocytoma, neuroblastoma, ganglioneuroma, and chromaffin adenoma or paragangliomata.

The gross anatomy of the system is shown graphically in the accompanying diagram. (Figure 1.) According to Langley's terminology[13] we designate the entire system as the autonomic nervous system. This is divided into the sympathetic, and the parasympathetic. Both of these systems have terminations in most structures of the body and their actions are in general mutually antagonistic. The sympathetic system proper consists of the chain and ganglia which can be seen in the diagram arising from the thoracic and lumbar portions of the cord. The connection with the central nervous system is

*Read at a meeting of the Summit County Medical Society, Akron, Ohio, March 1, 1932.

through the so-called white rami communicantes. These are medullated fibres which leave the spinal cord through the anterior roots of the spinal nerves and extend for varying distances in the chain to end either in the ganglia or in the end stations in the viscera. They are spoken of as preganglionic fibres and emerge usually only from the first thoracic to the second lumbar segments of the cord. They are supposed to contain efferent motor fibres only.

After synaptic connections in the various ganglia, non-medullated fibres arise, the so-called postganglionic fibres, which may proceed to the end receptors in the viscera, or elsewhere, or connect with the spinal nerves through the so-called gray rami communicantes which are not shown in this scheme. There is still a controversy as to whether any of these fibres carry sensory impulses. From a clinical point of view it is generally accepted that they do mediate certain modalities of sensation.[17] The parasympathetic system arises by preganglionic fibres which flow out from two main regions, cranial and sacral. The cranial group accompany certain of the cranial nerves, notably the Third to the pupil, the Seventh and Ninth to the various glands of the face and neck, and the Tenth to the thoracic and abdominal viscera. The sacral group flow out in a very inconstant arrangement anatomically to the rectum, bladder and genitalia.

The mutual antagonistic action of these two branches of the autonomic system can be illustrated by the effect on the pupil, stimulation of the branch from the sympathetic, causing dilatation, while stimulation of the parasympathetic causes contraction. The same sort of differences can be demonstrated pharmacologically, e.g., adrenalin and pituitrin are sympathetic stimulants while ergotamine depresses this system. Pilocarpine, its ally eserin, choline and acetylcholine stimulate the parasympathetics, while atropine paralyzes the parasympathetic endings. The end receptors of these nerves in the viscera and elsewhere are not recognized with certainty. In the intestine the plexuses of Meisser and of Auerbach are so regarded, but the sympathetic and parasympathetic endings cannot be separated. As a result of numerous experimental observations it seems clear that while the fibres from the sympathetic chain exert a general governing effect, the end plexuses themselves have a certain amount of autonomy and can function independently of their central connections. Such a conception may explain the temporary beneficial effects of certain operations which are later followed by reversion to the original condition. Hunter and Royle demonstrated what they interpreted as end stations of the sympathetic nerves in the voluntary musculature of the body, but other observers have been unable to confirm their findings.

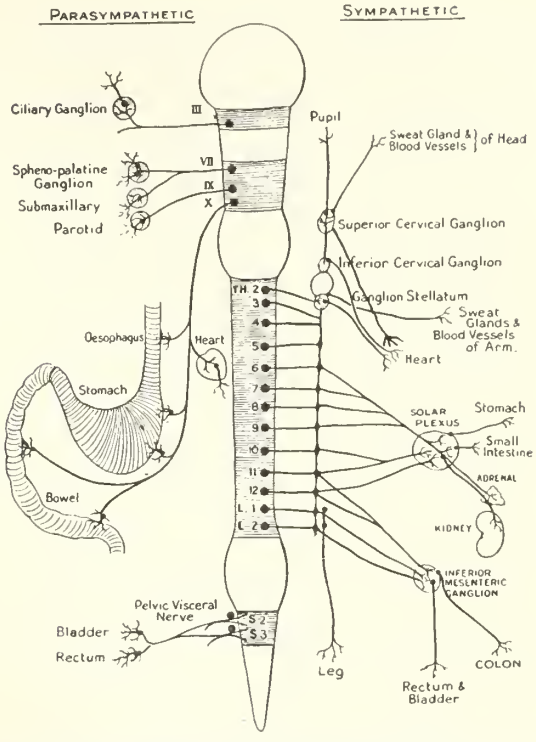


FIG. 1. Scheme of the general arrangement of the Autonomic Nervous System, the distribution of the Sympathetic and Para-sympathetic portions being contrasted on the two sides of the diagram.

To proceed now to more specific considerations let us first consider the operation for angina pectoris. As stated previously, removal of the cervical sympathetic for this condition was first suggested by Franck in 1899, but actually first done in 1916 by Jonesco. Many reports appeared in the American literature from 1923-26. There were described at that time three main sympathetic supplies to the heart, the superior, middle and inferior cardiac nerves. The first arises from the superior cervical ganglion, the second from an intermediate level in the cervical chain, and the third from the inferior cervical or the stellate ganglion. In the earlier operations various procedures were done from simple section of the chain to removal of the entire cervical cord plus the stellate ganglion. In general, however, the attention was directed principally to the upper and middle portions of the chain. As a result of more intense anatomical and physiological investigation it gradually became evident that all the important fibres to the heart through the cervical chain must emerge from the cord at the level of the stellate gangion or lower, as there are no white rami above this level. It thus was recognized that removal of the stellate ganglion or division of all its branches would effectively interrupt all efferent and probably most afferent fibres.

The mechanism of cardiac pain and its abolition by removal of the stellate ganglion is not clear—

whether it is due to interruption of sensory paths alone, or to removal of motor fibres which cause painful spasms, or to a combination of these two, i.e., by reflexes. It has even been suggested that the relief of pain is due solely to the vasodilation of the blood vessels of the heart which follows removal of the vasoconstrictor effect by division of the sympathetic fibres and is not due to either motor or sensory impulses mediated through the autonomic system. The accompanying diagram (Figure 2) shows the more detailed anatomy and the presumed pathways of efferent and afferent nerves to the heart. They demonstrate clearly the importance of isolating or removing the stellate ganglion as most or all of the afferent and efferent fibres pass through this ganglion. Recently Kuntz and Jonesco have presented anatomic evidence of the necessity of intercepting the chain below this level. Kuntz[12] found that in 48 cadavers there was an intrathoracic ramus connecting the 1st and 2d thoracic nerves present bilaterally in 21 and unilaterally in 9. Jonesco[9] was able to trace thoracic cardiac nerves which passed more or less directly to the heart from as low as the 5th thoracic ganglion. These were present, and fairly constant, in the cat, dog, calf, lamb, and in the human fetus at term.

As a result of all this evidence the operative attack on the cervical sympathetic has been directed to lower and lower levels till now it is limited almost exclusively to the stellate and upper thoracic ganglia. Also, in accordance with other developments, a large proportion of patients are now treated by paralysis of the sympathetic fibres at this level by alcohol injection into the ganglia, rather than by operative removal. As a result of removal of the stellate ganglion and the cervical sympathetic chain there occurs a very definite set of symptoms. There is increased vascularity with increased surface temperature of one-half the face and neck and the entire upper extremity of the same side, associated with absence of sweating over the same skin area. There also develops a Horner's syndrome consisting of contraction of the pupil, enopthalmos and narrowing of the palpebral fissure. Occasionally wide-spread sensory and motor changes follow removal of the cervical sympathetic. These have been particularly studied by Reid.[22]

Recently Mixter and White[17] have reported some unusual types of pain of the head and neck cured or relieved by cervical or upper thoracic ganglionectomy.

Let us turn now to the operation of periarterial sympathectomy reported by Leriche[15] in 1921. Leriche believed that many painful and other lesions of the extremities were due to insufficient vascular supply caused by hyperactivity of the sympathetic vaso-constrictor fibres to the small peripheral vessels. He believed that these fibres traveled along the main vessels in their sheaths to reach the smaller terminal arterioles. By excising a collar of the periarterial tissues, 8-10 cm. long, he hoped to remove the effect of these constrictor fibres and allow vasodilatation to take place. He described two reactions which occurred when this operation was done. First, at the time of operation, there was a marked diminution in the calibre of the artery at the site of the operative manipulation, associated with marked diminution of the peripheral circulation with such signs as local asphyxia, coldness, and diminution in width of capillaries This first stage lasted one to three hours to be succeeded by the exact reverse phenomena, namely increased vascularity, increase in redness, local heat, etc. Such a phase lasts for a period of five to six days, then gradually fades and disappears after three to four weeks, a fact which I think has been insufficiently recognized by many who have not obtained satisfactory results by this method.

Leriche found and still finds applications for this operation in painful causalgias, painful amputation stump with deficient circulation, trophic ulceration, stupeur arterioelle, etc., but not in thrombo-angiitis obliterans. It is interesting to note that in 1921 he called attention to the similarity of the reaction he obtained by this operation to that obtained in a rabbit's ear by removal of the cervical sympathetic.

The experience of other surgeons with Leriche's operation has not been favorable in the majority

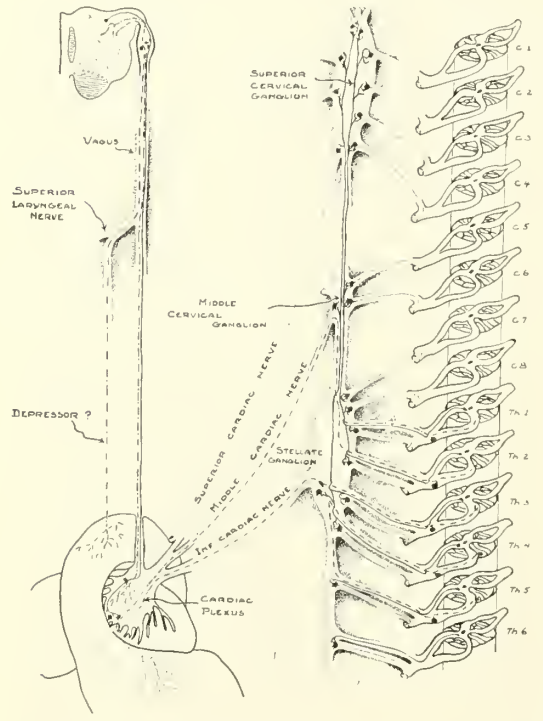


FIG. 2. Chart of sympathetics showing afferent and efferent fibres to the heart (after Huber).
Preganglionic efferent fibres——————Post ganglionic fibres .....
Afferent fibres —— · —— · ——

of instances though occasionally very striking results are obtained.[3] From an anatomic and physiologic viewpoint it is generally believed to be without adequate basis, since it has been fairly conclusively demonstrated that the vasoconstrictor distribution to the blood vessels is segmental and not along the large arteries. This may be illustrated as follows: The preganglionic white fibres destined for the blood vessels, leave the spinal cord and enter the sympathetic chain through the white rami. After synaptic connection in the ganglia, gray post-ganglionic fibres arise, rejoin the somatic nerves through the gray rami and are then distributed segmentally with these nerves. If such a distribution exists it is obvious that periarterial sympathectomy could be expected to exert vasomotor changes only at the actual site of operation and not peripherally unless by a reflex effect through afferent fibres from this area. It is interesting to note that very recently Leriche[16] reports favorable results obtained by excising segments of arteries themselves rather than decorticating them. He has used this procedure in a number of instances where the artery was occluded, especially in occlusions due to trauma, and reports that palpable pulsation developed peripherally in cases in which it was perviously absent. He and his associates have also demonstrated that it is possible to remove all the major blood vessels of both extremities in dogs without impairment of the peripheral circulation. For example, in successive stages, both common iliac, both femoral, both gluteal, and both posterior tibial arteries have been removed, and the animal still retains apparently uninterrrupted peripheral circulation. He attributes this unexpected finding to the interruption of the vasoconstrictor fibres to the peripheral vessels. He found, also, that more extensive single stage procedures could be carried out if bilateral lumbar ganglionectomy was first performed.

The other important developments in the surgery of the sympathetic nervous system have come from the original observations of Hunter and Royle.[24] These investigators believed that the tone of skeletal muscle was maintained by sympathetic fibres, and demonstrated what they took to be end plates or receptors of these fibres in the muscles. As a result of these findings and certain experimental observations they believed they could diminish the spasm or tone of the muscles in certain spastic paraplegias by dividing the gray rami, an operation which they called ramisection. Following the operation, in selected cases, they noted not only improvement in the spasticity of the muscles, but also evidences of increased circulation in the extremity, absence of sweating, and a tendency to the cure of chronic constipation which generally accompanied the spastic paraplegia. These findings they correctly interpreted as due to paralysis of the vasoconstrictor nerves to the blood vessels, and the inhibitory fibres to the large intestine.

Investigators all over the world failed to confirm the anatomic and histologic findings of Hunter, or the experimental and clinical results on spasticity after ramisection, so that the operation has not been continued as a treatment for spastic conditions. The value of the general procedure in the treatment of peripheral vascular disease, arthritis, and Hirschsprung's disease soon became apparent. The operation of Royle was soon modified, however. Instead of approaching the lumbar rami from in back, necessitating two separate incisions and approaches for bilateral ramisection, the lumbar sympathetics were approached through the abdomen. In this country the technique described by Adson[10] or that by Kanavel and Davis[11] is generally followed. The procedure was quickly extended to include not only ramisection but also ganglionectomy, i.e., removal of the lumbar sympathetic chain with the ganglia, as this more extensive operation was found to be more efficacious. For the upper extremity it was soon found that removal of the stellate ganglion was more essential than section of the gray rami in the neck as first advocated by Hunter and Royle. At first this ganglion was removed through the neck. Later, Henry of Dublin, demonstrated that the ganglion was more easily accessible if approached from behind, by resection of the second rib near the spine. Adson first used this approach in a patient and his technique is now the standard method.[2] Owing to the work of Kuntz and others previously mentioned, it is now believed advisable to remove the second thoracic ganglion in addition to the stellate. As a result of lumbar ganglionectomy there develops a vasodilatation of the blood vessels of the extremity of the same side, due to interruption of the sympathetic vasoconstrictor fibres. In addition there is dryness of the skin due to absence of sweating which is also controlled by the sympathetic fibres. The sympathetics also act as inhibitors to peristalsis of the intestine, so that lumbar ganglionectomy by removing this inhibitory action causes increased peristaltic activity.

Let us now enumerate the general types of cases in which ganglionectomy and ramisection is believed to be indicated. First of all, there are the instances of decreased vascular supply to the extremities, especially Raynaud's disease and allied angio-spastic conditions; second, Hirschsprung's disease; third, arthritis deformans; fourth, bladder disturbances. So far as the vascular diseases of the extremities are concerned, it is apparent that the operation could be expected to be of value only in those cases in which spasm of the artery is the sole or contributing cause, while no effect could be expected in those where the decreased circulation is due solely to arterial occlusion.

The first test which was found to be of value to

determine the presence of spasm, was the increase in the circulation and increase in the surface temperature of the extremities which developed following the induction of foreign protein shock. This method developed by Brown[5] has been of therapeutic as well as diagnostic significance owing to the prolonged vasodilator effect. The protein shock is produced by injection intravenously of 50-250 million killed typhoid bacilli. It is essential that the extremities be preheated and wrapped in blankets as there may be a primary chill with slowing of the circulation which may last two hours.[28] During this period thrombosis may develop particularly if there is arterial disease present, and this can be avoided by the pre-heating. Following the latent period of two hours, the general body temperature rises rapidly in about four hours to its maximum, and then falls in about six hours to normal. The maximum usually obtained is about 103° F.

During this time the peripheral circulation increases, the extremity becomes warmer, drier, and of a better color. The surface temperature may rise as much as 15° F., and it may take as long as a week for it to fall to its original level. In general the changes in surface temperature obtained by this method were thought to be permanent following ganglionectomy. The method is contraindicated in cases of senile arteriosclerosis and should rarely be used in patients older than fifty years. In May, 1930, White[30] reported that similar changes could be obtained in the surface temperature of the extremities by the use of novocaine blockage of the nerves either by spinal anesthesia, by direct infiltration of the sympathetic ganglia, or by conduction block of the peripheral nerve trunks, e.g., the sciatic nerve. He gives credit to Lewis for having injected the ulnar nerve in a case of Raynaud's disease in 1929.

At about the same time that White's report appeared Morton and Scott[18] also advocated the use of spinal anesthesia for the same purpose and in subsequent reports found that the same effect could be obtained by general anesthesia.[26] They further made a definite effort to standardize the procedure. Their first contribution was the development of a simple, portable and easily applied thermocouple called the dermatherm—manufactured by the Taylor Instrument Company.[25] Prior to this instrument it was necessary with most thermocouples to insert a needle into the subcutaneous tissues so that rapid readings at various points was impossible. With the dermatherm it became possible to make rapid and accurate readings of surface temperatures without pain to the patient.

They soon recognized also the necessity of a constant and standard room temperature and finally have settled on 20° C. as the most suitable. Under such conditions they found in normal persons what they termed the "normal vasodilatation level".[18] They found that in normal individuals kept nude for 20 to 30 minutes in a room at temperature of 20° C., there is a gradually decreasing temperature of the skin surface from the thighs to the toes, the under surface of the great toe being the coldest skin surface. This gradual decrease in surface temperature they termed the "normal vasoconstrictor gradient". If this vasoconstrictor gradient is now abolished by general anesthesia or by spinal anesthesia, the under surface of the great toe should reach 31.2° C. which is the normal vasodilatation level. Any degree reached less than this level if subtracted from it gives the "occlusion index". If the room temperature varies from 20° C., 0.3° C., should be added or subtracted from the skin reading for every degree C. by which the room varies from 20° C.

Using these definite and standard criteria they conclude that in deficient circulation in the extremities if the maximum temperature following anesthesia goes as high as 30.5° C., or higher, vasoconstrictor spasm is the sole cause of the circulatory deficiency. If there is no increase in temperature, vasoconstriction plays no rôle. If there is an increase but the normal vasodilatation level is not reached, there is present a mixed condition, spasm plus occlusion. They are very definite in their belief that the amount of change in surface temperature is not as significant a criterion as the level to which the temperature goes.[19] In a recent contribution they have reported a method of blocking the posterior tibial nerve at the internal malleolus for use especially in ambulatory patients. This gives the same type of response as spinal or general anesthesia, but is more local in its effect, and somewhat less efficient, the "normal vasodilatation level" being slightly lower.[27]

It is obvious I believe that by these means one can determine those cases of circulatory deficiency in which spasm plays an important rôle. All such cases should be benefited by ganglionectomy. In this connection it is interesting to note that Eddy and Taylor[7] have recently published an extensive series of observations of the normal surface temperatures of virtually the entire body by selecting 52 separate points in each of fifty persons. Their charts showing the average, mean, maximum and minimum temperatures for these 52 points are very important as normal standards to anyone engaged in this work.

In 1925 Adson[1] reported the marked improvement in a case of Hirschsprung's disease treated by bilateral lumbar ganglionectomy and ramisection, and since then numerous reports have appeared. The rationale of the procedure is somewhat as follows: It is now generally believed that the principal cause of this condition is a faulty ennervation of the large bowel consisting of failure of the sphincters to relax accompanied by insufficient peristaltic activity. The physiologic investigations have shown that parasympathetic activity tends to cause peristalsis with relaxation

of the sphincters, i.e., it is the emptying system; while sympathetic activity tends to paralyze peristalsis and cause contraction of the sphincters, i.e., it is the filling system. In Hirschsprung's disease there is assumed to be an hyperactivity of the sympathetic system, but it is unknown whether this is due to an irritative lesion of the ganglia, of the postganglionic or preganglionic fibres, or whether it is central. In any event, ganglionectomy removes the inhibitory effect of the sympathetic fibres.

Before deciding on ganglionectomy in the treatment of this condition a therapeutic test can be made, by inducing spinal anesthesia after barium enema and with the patient on the fluoroscopic table. In the typical case, the patient is unable to expel the enema until after the spinal anesthesia. Recently Rankin and Learmonth[21] have obtained satisfactory results in these cases by division of the so-called pre-sacral nerve and the inferior mesenteric nerve only. Their physiologic and experimental studies are too detailed to report here, but these indicated that by dividing these nerves alone they paralyzed the sympathetic supply to the large bowel and rectum without disturbing the sympathetic supply to the extremities as would be done by ganglionectomy.

Still other applications for ganglionectomy have been reported. Among these may be mentioned its use in disturbances in swallowing due to spasm of the oesophagus, and relief of hypertrophic pyloric stenosis, though so far as I am aware no actual operation on the sympathetic nerves has been done for this latter condition. Rowntree and Adson[23] have reported good results in the treatment of chronic polyarthritis by ganglionectomy. Most other observers have found that in such conditions they can produce a condition of warmth and dryness of the extremities in place of coldness and clamminess, but little or no improvement in the arthritis itself. Finally, Learmonth[14] has reported the value of division of the presacral nerve for certain cases of "spinal bladder" to facilitate emptying of the bladder. He also advocates division of the parasympathetic nerves to the bladder in cases of intractable painful spasms of the viscus.

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Value of Heredity Emphasized

"I come to the conclusion that doctors know too little about heredity, think too little about it, act too little about it, are interested too little; and that brings me straight to this group. I think we ought to advocate and get permeating through the medical curriculum just as much knowledge of heredity and just as much mature opinion about its application as is possible. I have no program, but as I conceive it, somewhere the fundamental facts should be presented plainly and clearly to medical students, and the practical importance of the facts should be stressed. The rest should be left to the clinical teachers who should emphasize and teach on it at every opportunity."—E. P. Lyon, dean, University of Minnesota Medical School.

Congenital Absence of the Abdominal Muscles

CASE REPORTS*

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AGENESIS, or congenital absence of the muscles of the abdominal wall, is an extremely rare condition. It is understood that the term is used in a clinical or physiological sense only, since it is difficult to prove the absence from an anatomical standpoint without the histological examination. One of the earliest reports of this rare condition was in 1896 by Guthrie[1]. The first compilation of cases was made by Stumme[2] in 1903, followed by the addition of two other cases in 1905 by Garrod and Davies[3]. In 1909 the previous twelve cases were chronologically arranged and the thirteenth added by Mollison[4]. In 1913, Thatcher[5] reported a case with anomaly of the urinary organs, a condition which had previously been noted by Osler[6] in 1901. Smith[7] presented a case with double talipes calcaneovalgus. To this group of fifteen cases, Ikeda and Stoesser[8] added the sixteenth in 1927. Hofstein[9] in 1930, collected the 22 known cases and added his one case, which is the only instance in the female. Malõssi and Gelli[10] reported the last case in 1931, although this infant showed considerable evidence of muscle tissue at autopsy.

The congenital absence of individual muscles is very rare, while the absence of a group of muscles is much less common. The most frequent defect is that of the pectoralis which was observed by Scheslinger five times in 54,000. patients. Yet by 1909 there had been reported 186 cases of this deformity in comparison with eleven of abdominal defect. Of the abdominal group, the oblique muscles are the most frequently involved while the rectus is affected the least.

The etiology of this condition is unknown. In addition to numerous mechanical causes there have been advanced many other reasons, such as intra-uterine infection, toxemias, hereditary influences, intra-uterine pressure and amniotic abnormalities. Syphilis has been thought to be a factor in a case presented by Brindeau and Jacquet[11] in which there was syphilitic ulceration of the umbilicus. In all probability the syphilis was a co-incidental condition and not the true etiological factor.

Several of these cases show definite genito-urinary abnormalities such as marked dilatation and hypertrophy of the bladder wall, hypospadias, undescended testicles and hernia. It has been thought, especially by Stumme, that sometime during intra-uterine development, an ischemia of the abdominal muscle is produced by the marked pressure of the distended bladder which results in a muscular atrophy. However, it is more likely, as mentioned by Pels-Leusden[12], that the vesical hypertrophy is probably a result of the muscle absence.

From an embryological standpoint[13], the method of development of the abdominal muscles may suggest a cause for this difficulty. The somite from which the muscles ultimately develop, begins in embryos of about the 17 m.m. stage and continues until there are 38 to 41 pairs. Each somite is primarily a mass of cuboidal cells, the center of which hollows out to form the transcient myocele. The lateral wall of this differentiates to form the dermatone and the dorsal wall closes down gradually to form the myotome or muscle plate. This plate increases in thickness as it grows ventrally with its cells becoming fusiform with their long axes parallel to the dorsal margin of the plate. The ventral ends of the myotomes fuse to form a ventral myotomic column.

The superficial portion of the myotomes lose their segmented character very early and fuse to form a longitudinal myotomic column from which the deep muscles of the neck and back are formed. The ventral margin of the myotomic column grows ventrally into the body wall and gives rise to the muscles of the neck, chest, abdominal wall and part of the diaphram. Longitudinal fusion of the ventral ends of the myotomes form such muscles as the rectus abdominis. Tangential splitting of the fused myotomes gives rise to the obliques and transversalis muscles.

Hence from this standpoint there are the following possibilities:

First, no myotomes develop, in which case there would be absence of the derived back muscles as well.

Second, the myotomes do not descend into the ventral wall, or a modification of this in that they descend part way which results in partial development of the muscular group. This undoubtedly is the case in the third of our reported cases.

Third, there is lack of longitudinal fusion of the ventral ends or lack of tangential splitting of the myotomes to form the transversalis muscles.

Fourth, the muscles develop normally, and later partially or completely atrophy. This may be due to the pressure of an enormously distended bladder during early embryonic life as suggested by Stumme. This might account for those clinically complete cases which histologically show muscle fibers. There may also be the lack of proper connection between the individual myotomes and

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neurotomes, resulting in improper innervation of the individual muscles.

Of these possibilities the second, or improper ventral descent of the myotomes seems to account for more of the cases. No reason, however, can be advanced for this.

In the histological examination of the cases reported by Ikeda and Stoesser, sections from the mid-line of the abdomen showed a normal skin with a wide zone of adipose tissue and only a few fragments of striated muscle fibers resting on a definite transversalis fascia. From a lateral part of the abdomen there was found some evidence of definite fascial planes but no evidence of muscle tissue.

One is interested from a prognostic standpoint in first, what will be the value of therapeutic agents and second, what will be the effect on the future life of the child. To this end, it is well to consider the effect of the abdominal muscles on the function of the abdominal organs. The intra-abdominal pressure is maintained alone by these, assisted somewhat by the diaphram and thoracic muscles. This pressure influences peristalsis, micturition and defecation. For this reason cystitis, vesical hypertrophy, urinary retention and pyelonephritis are very common complications. Constipation and intestinal toxemias are very prone to occur.

The dome contour of the diaphragm and cylindrical shape of the chest are maintained by these muscles. The type of respiration is changed from the normal abdominal to the thoracic. As a result of this improper aeration, there is danger of pulmonary infection and bronchial or lobar pneumonia. For these reasons, prognosis for continuance of life is rather unfavorable. These various complications and associated conditions have been very well illustrated by our second case, and yet he has shown quite normal physical and mental development.

Partial mal-formation of one or two abdominal muscles may result in an herniation through the thin abdominal wall. Such a case was reported by Levy[14] in 1908.

The treatment of this condition may be divided into *first*, mechanical devices to support the abdominal wall. This may be either an elastic bandage applied moderately tight over the entire abdomen and chest with particular attention to pressure over the bladder region; or, in older individuals a non-elastic corset with stays may be used. An abdominal support should be used during infancy to protect the organs from injury and to supply in part the function of the absent muscles; and to facilitate creeping and walking. An elastic band, connecting the shoulders and the pubic region to counter-balance the back muscles, may be of value. *Second*, normal dietetic and routine infant care is indicated; and *third*, particular attention to prevention of exposure to disease.

CASE REPORTS

J. S.—a boy, aged four weeks, was the first child of normal parents. The infant, weighing seven and one-half pounds, was born at full term. The delivery was normal, following an uneventful pregnancy. He had been breast fed regularly without any difficulty in nursing and without any nutritional disturbance except an occasional regurgitation. He had been satisfied and had gained weight at a satisfactory rate.

He was first seen November 9, 1931, with the chief complaint of marked relaxation and redundancy of the abdominal wall. The mother stated this was noticed immediately after birth, together with a marked dryness and scaling of skin of the abdominal wall, and a moderate retraction of the head, neck and back.

Physical examination revealed a well nourished boy of four weeks. The head and neck were normal. The thorax was apparently shorter than normal and in proportion to the greatly relaxed abdomen. This was exaggerated by a forward and upward tilting of the sternum and lower ribs due to the absence of the bow string effect of the recti muscles. The heart, which could be palpated through the abdominal wall and diaphragm, was normal in rate, rhythm and sound, and was not displaced. The lungs were equally expanded and normal in sound. The liver dullness was two interspaces lower than normal. The respiration was entirely thoracic. The abdomen was large, pendulous and bulging in both flanks but more marked in the right. The skin was covered by large, coarse areas of desquamation, giving it the appearance of parchment. In addition, there were numerous transverse wrinkles and fissures in the lower part and longitudinal ones about the umbilicus. This latter structure was slit-like in appearance and admitted a probe for 3 c.m. towards the bladder.

The superficial abdominal organs were distinctly visible through the thin wall. On palpation, the wall seemed to be only skin and subcutaneous tissue without any muscle. All of the organs could be outlined with ease except the liver, which was covered by the distended colon. A variable hard mass appeared in the midline above the pubic arch and extended upwards for a distance of 5 c.m. This was 3 or 4 c.m. in diameter and was apparently a hypertrophied and enlarged bladder.

X-ray examination emphasized the redundancy of the wall by showing the coils of the small intestine outside the lateral limits of the trunk. The diaphragm was flattened due to greater intrathoracic pressure. The liver shadow was decidedly reduced due to a partial rotation of this organ. The skeletal and thoracic musculature was normal. There was a double talipes equinovarus. The testes were undescended. At six months of age the child had developed at a normal rate but with no evidence of abdominal musculature.

April 8, the patient developed pneumonia and died April 14, 1932. No autopsy was obtained.

C. T., aged 17 years, was studied April 20, 1932. He was the second child of normal, well, white, American parents. The pregnancy and delivery had been normal and uneventful. The birthweight was eight pounds. The attending physician stated the baby would not live due to the defect of the abdominal wall. The skin over the abdomen was greatly relaxed and hung in folds. There was some keratosis with numerous fissures arranged both transversely and longitudinally, which made cleanliness very difficult. There was extreme retraction of the head and neck to a right angle. The ribs and sternum turned upward, producing a

relatively shortened thorax. The naval was not patent and was difficult to locate.

Breast feeding was continued for six months, followed by numerous formulae, at which time his weight had increased to 12½ pounds only to fall to ten pounds at one year. During this time there had been one attack of severe bronchitis and several attacks of enteritis preceded by constipation and accompanied by fever and vomiting. At two years the weight was 18 pounds. The teeth appeared at nine months; talking at 18 months; and walking at three years, immediately after the use of a heavily stayed corset. This corset was preceded during infancy by a wide abdominal band.

From two to 13 years there had been quite severe, recurrent attacks of high fever and vomiting, diagnosed as pyelitis or pyelonephritis. At eight years, he developed acute nephritis with considerable edema, bloody urine and frequent, painful urination, but no toxic signs. Cystoscopic examination at that time revealed a distended hypertrophied bladder with marked cystitis and purulent ureteral discharge from the right side. These attacks became less frequent until the present when they occur every three or four months.

At present, urination is somewhat frequent but may be quite painful when it is retained for several hours. This is usually accompanied by large amounts of pus and mucus and at times blood.

There were double congenital flat feet but no other abnormalities were noted.

Physical examination presents a 17 year old male, somewhat below the average in height and weight. He weighed 76 pounds and was 53 inches high. The head was of normal size, the ears, nose, eyes and throat showed no abnormalities. The tonsils had been removed. His intelligence was average as well as his activities and relation to other children. The neck was short. The chest was normal in contour in the upper half but irregular in the lower half, where there was a marked depression on either side, which seemed to involve only the false ribs. The sternum curved forward and then back at the junction of the lower and middle thirds. A moderate degree of scoliosis to the left, which was purely postural, resulted in an enlargement of the left chest posteriorly, accentuated by drooping of the left shoulder. The vertebrae were normal. The chest sounds were not abnormal. He was unable to show any evidence of voluntary contraction in any part of the abdominal wall, nor could he raise himself to the sitting position except by the use of his arms. The respiration was entirely thoracic and confined to the upper three-fourths of the chest.

The abdomen was large, moderately distended and very pendulous with more pouching on the right side. This was more marked in the prone position. The skin was slightly wrinkled transversely above the naval but was fairly smooth below.

There was a deep fold throughout the length of the linea alba. When standing without the belt, the skin became mottled, but the veins collapsed when he was in the prone position. To the touch, the abdominal wall was quite soft and doughy with no evidence of elasticity or resiliency. It seemed nearly normal in thickness. The umbilicus, located higher than the average, was only a pit in the skin. There was no opening.

The liver was 11-12 c.m. below the costal margin, which permitted palpation of the superior surface. The other abdominal organs could be palpated with ease. The bladder dullness extended nearly to the umbilicus. There was no tenderness found anywhere except deep over the right kidney. The testicles were not descended and the scrotum was small. Puberty evidently was delayed, although there was some pubic and axillary hair. However, this delay cannot be attributed to the defect but rather to the various illnesses which have resulted from the defective mechanics of the chest and abdomen. He was unable to empty the bladder completely or to defecate without the abdominal belt, although this was not worn during the night.

His general condition is not good although his desire for activity is nearly normal. The prognosis for extended life is very poor due to the pyelonephritis.

W. M., white, male, aged six weeks, was observed February 16, 1932. He was a full term, normal infant weighing nine pounds, eleven ounces at birth. The pregnancy was uneventful, followed by a prolonged but normal delivery. During the lying-in period no abnormality was noticed. At three weeks of age, the parents first noticed a bulging recurring mass in the left side of the abdomen.

At the time of the examination, the only abnormality noted was this mass, which occurred with straining. It was about 12 c.m. in diameter and protruded four and one-half c.m. It filled the entire left side from the iliac crest to two c.m. below the costal margin. No areas of induration or density were noted on palpation. The abdominal wall was thin over this region but the skin was normal in texture and resiliency. The genito-urinary system and the breathing were normal. A pad firmly held in place by an elastic belt was sufficient to afford complete relief.

This case presents a defect in the left transversalis or oblique muscles. However, it cannot be said with certainty that there is a complete absence of muscle due to the texture of the skin and the maintenance of a fairly normal abdominal contour except during exertion. The prognosis is very favorable in this instance. There is the possibility of development of hernia, during the repair of which there would be opportunity for the verification of the extent of the defect. This same condition was noted in a 70 year old male by Levy, for relief of a strangulated hernia.

SUMMARY

(1) There have been presented three cases of congenital deformity of the anterior abdominal wall. One of these, an infant, shows definite evidence of anomaly of the genito-urinary system. The second is that of a boy of 17 years who shows the same extensive defect, and who has demonstrated practically all of the possible complications. The third case presents defect in the left side.

(2) The complete defect apparently is incompatible with longevity.

(3) The literature has been reviewed and theories advanced as to the etiology of the condition.

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DISCUSSION

R. S. FRIEDLEY, M.D., Akron, Ohio: As Dr. Baxter stated in his paper, congenital absence of the abdominal muscles is a rare condition.

From 1896 there have been only eleven cases reported. Two years ago having had a case of "Agenesis of the Abdominal Muscles," I tried to find something at that time in the literature and was able to locate only a few references to this condition.

In the British Journal "*Disease of Children*", 1929, there is an extract of Dr. D. Basi's paper. The child was two months of age, male, and presented the following conditions: A marked protrusion on the right side, due to a distended caecum and ascending colon, on the left a distension of the small intestines and descending colon. There was obstinate constipation, the bowels being moved only every fourth to fifth day with evident pain. An elastic abdominal belt was applied with benefit relieving constipation and improvement in the general health. In the same Journal in 1931 there was an extract from a paper by Dr. A. Moncrief. His case was six months of age and died of double pneumonia. On autopsy the abdominal muscles were entirely lacking, the spinal muscles being present. The kidneys were enlarged, ureters were greatly enlarged and convoluted. It was impossible to pass a probe from the bladder into either ureter, due to the convolutions acting like a valve. The urachus was still intact and the bladder walls were greatly thickened.

My case was a male child one year of age. When first seen by me the child was in convulsions, dying within eighteen hours from uremia. On autopsy the following conditions were noted: Making an incision in midline underneath the skin there was a small amount of subcutaneous fat with a few thin bundles of striated muscle fiber. The spinal muscles were normal. The kidneys were enlarged one-half their normal size. The ureters measured a half to one inch in width, and at the distal end there was a fold of the inner lining acting like a valve. The bladder was enlarged and the wall was a half-inch thick. It was impossible to pass a probe from the bladder into the left ureter while a small probe could be passed from the bladder into the right ureter, a catheter could be passed from the bladder through the penis and from the penis into the bladder.

Dr. Baxter has referred to cystitis, vesical hypertrophy, urinary retention and pyelo-nephritis as very common complications; other authors have referred to this condition as being common. Dr. Baxter has already stated that the intra-abdominal pressure is maintained alone by the abdominal muscles assisted somewhat by the diaphragm and thoracic muscles.

Unless some satisfactory abdominal support can be used to function as abdominal muscles, I believe, as already stated by Dr. Baxter, that some one or all of the genito-urinary symptoms will manifest themselves.

Some Present Day Ideas Concerning Heart Disease From the Public Health Point of View

By JULIEN E. BENJAMIN, M.D., Cincinnati, Ohio

THE only really satisfactory and successful campaigns ever conducted by public health workers for the prevention and relief of a supposedly controllable disease, have been those directed against illnesses for which there was a known specific cure or prevention. Where this has not been true, the control of such disease merely through channels of education has met with great reverses, and occasionally most unsuccessful efforts. One has only to consider the results of activities in the war against diphtheria and smallpox compared to the accomplishments in the battle against tuberculosis and syphilis. Brilliant results in the former; discouragement in the latter.

Read before the Section on Public Health and Industrial Medicine, Ohio State Medical Association, at the 86th Annual Meeting, Dayton, May 3-4, 1932.

For the past ten years heart disease has attracted the attention of the world because of its ravages and apparent increase in incidence, (Plate 1), and also because students of the subject have vouched for the fact that much of it is preventable. Now, theoretically this may well be true. Practically, it is not nearly so true. This being the case, are we not running the chance at least in a measure of defeating our purpose? In spreading propaganda consisting mostly of terrifying data, without adequate reliable information concerning cure or prevention, is it not perfectly possible that the laity may lose interest, if not confidence?

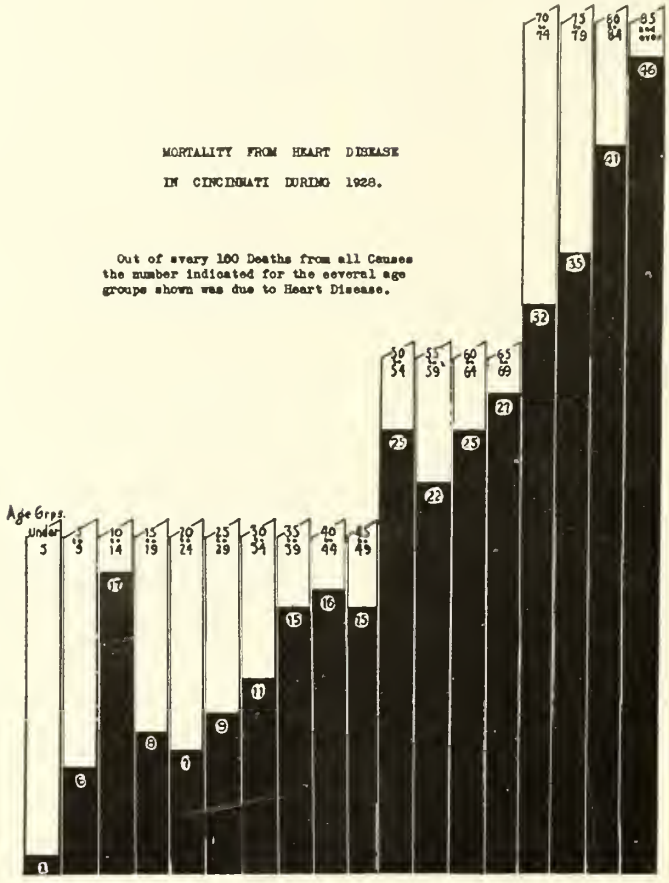
A few months ago, a movement was started in Cincinnati public health circles attempting to corral as many negroes as possible for the purpose of conducting physical examinations. The

idea being to detect early signs of tuberculosis and institute treatment, because of our experience that negroes with pulmonary tuberculosis are so often seen only when the disease is so far advanced. Curiously enough, very few early cases were found. While this was discouraging, it proved to be somewhat fortunate, for after the cases were found we were at a loss to know what to do with them. All available beds for the tuberculous were occupied. In lieu of this we could do nothing except send the sufferers back home and advise them to rest, and eat plenty of nourishing food. By the time beds were available, either the victims had disappeared, become seriously ill, or died. Certainly the results of this movement would not encourage negroes, or others, to seek physical examination as a protection against the inroads of tuberculosis. It is not sufficient merely to detect illness, if we wish to control it; adequate resources for its care must be provided in order to accomplish even reasonable results.

It is of course necessary to study carefully a problem in preventive medicine before its solution is possible. In order to do this in the domain of cardio-vascular diseases, many examinations had to be made. This meant educating the people as to what we were trying to do. After the examination, however, nothing or very little could be or was done. Why?

First—We knew too little about the arch enemy of the young, namely, acute rheumatic fever. That it predisposed to heart disease has been known for years. But how it was contracted, what caused it, or how to prevent infection, we could only hint at. The mothers were told that infected tonsils might cause rheumatic fever, but we have since found this far from the fact.

Second—It was considered essential for a child recovering from rheumatic fever to have months of convalescent care, so as to assure the heart reasonable immunity from valvular disease. But in nearly every locality, there were, and still are, a great scarcity of beds for convalescent care.



Third—Lues, the only really known preventable disease predisposing to heart disorders, we chose to defeat by educating the masses in self control, or offering cure by treating those infected, in "mass manner", at dispensaries where the chief object was "a shot a minute", without any interest as to whether the individuals ever returned or not.

Fourth—There remained an enormous number who had heart disease, the cause or causes of

which were not understood. As a matter of fact, it was very soon noted as data was studied, that the upward trend of mortality from heart disease occurred past the age of 40 years, in this very group; that in the past five years deaths due to rheumatic heart disease (early deaths) were actually decreasing.

Now, I wish principally to discuss the mortality and morbidity of the middle age group. It is true that the aging processes begin at or after the age of 45 years, or 50 years, but it is apparent that in many instances, more than the facts would justify, the decline is hastened by causes other than natural ones. I refer to that large group of sufferers well known to every busy practitioner, who appear to be in the best of health, but who are handicapped by symptoms referable to the circulatory system. They are usually robust individuals, somewhat plethoric, with enlarged girth, complaining of distress in the region of the heart on moderate exertion, or after meals, and early fatigue. These men are principally of the sedentary class and often men of affairs. A disportionately large number of physicians are included in the group; briefly, men who have heavy responsibilities.

The examinations are frequently unsatisfactory, and often the only clue one has to the disorder is the chief complaint of the patient. In some, a slightly elevated blood pressure is found with or without a slight trace of albumin and hyaline casts in the urine, or a moderate degree of diabetes. Some of these patients never get to the doctor's office for only too often they collapse and die suddenly of "acute indigestion" or are found dead in bed, or drop dead following a round of golf.

The medical directors of the leading life insurance companies, after studying their experiences with policy-holders carrying large amounts of insurance, have found that with few exceptions the mortality of this class is from 30 to 50 percent higher than that of the average. At present, large amounts of insurance are issued only to first class risks and where all known tests show the cardio-vascular system to be beyond reproach. It is significant, too, that the suicide rate in this class is two to three times greater than the average. A high suicide rate is perhaps the best index of emotional reaction and states which are usually expressed as worry, anxiety, frustrated ambitions or too much responsibility.

Thus we are confronted with a somewhat new and serious chapter in the field of preventive medicine. Periodic examinations often reveal little or nothing of importance in the cardio-vascular system. There are no murmurs at the valve areas. The size of the heart may be within normal bounds. The response to tests for myocardial efficiency may be prompt, and encouraging. Frequently the pathologist is at a loss to account for sudden issues.

Mention has just been made of the effect of long continued emotional strain and mental states, on the cardiac mechanism. True enough we cannot detect these changes under the microscope, but we have ample proof that mental stress may produce organic changes; intestines that will not digest food; kidneys that will not secrete urine, and I believe, hearts that will not properly pump blood.

In his article "The Heart and Emotional Conflicts",[1] Sidney Schwab calls attention to the fact that through a series of emotional experiences, the individual becomes accustomed to the phenomenon of altered heart action and regards it as of no consequence. He has reported a number of such cases and findings, the most outstanding clinical factor being a fairly constant tachycardia. These patients frequently have, in addition, an uneasy sensation over the precordium, respiratory increase, weakness, and insomnia. A picture like that of a true sufferer of organic heart disease as we have always understood that term. These symptoms, as well as their causes permitted to operate over a long time could eventually result in a weakened heart muscle.

It is not only the "men of affairs", the high livers, who suffer in this manner. Let me call your attention to a recent investigation conducted by Carey P. McCord and his associates.[2] One hundred and sixty-five train dispatchers were examined because it was known that the average expectancy of these individuals was 50.17 years, although a dispatcher enters upon his duties relatively late in life, near 32 years of age. He occupies the "spear head position in all train movements". He carries the burden of safety of the traveling public and train crew against catastrophies. For eight hours with phone clamped to his ear, frequently he may not leave his desk or remove his ear phone receiver. In addition to a high incidence of occupational nervous disorders, 65 per cent had albuminuria in some degree and 81.1 per cent had well recognized cardio-vascular disease, the majority between 35 and 55 years of age. McCord concludes that "Having ruled out any high prevalence of syphilis, and by careful clinical observations, having ruled out a higher frequency of other infections than may be expected to obtain in all males of comparable age, social and economic status, by careful history taking and clinical observation, we are prompted to believe, that portions of this unusual extent of organic cardio-vascular abnormality, are the results of prolonged overwhelming mental strain, in short, organic impairment from mental trauma."

This beautiful piece of work challenges serious attention, as it is the first rather conclusive clinical proof (by exclusion, true enough) offered to substantiate the fact that organic disease may occur in this manner. It might be of interest to note the various criteria governing the final diagnosis of existing cardio-vascular disease.

McCord has wisely compared the results of this

survey with those obtained when he examined 1000 office workers and 1000 factory workers for the Heart Council of Greater Cincinnati.[3] Here the idea was to see how much unsuspected disease of the circulatory system existed in workers who considered themselves in good health. I shall have more to say of this survey a bit later. Let us consider for a moment the following comparisons:

1. *Significant Cardiac Hypertrophy.*

Of the total number examined 12 percent of the office workers, 7.5 percent of the factory workers and 37.6 percent of the dispatchers had appreciable enlargement of the heart.

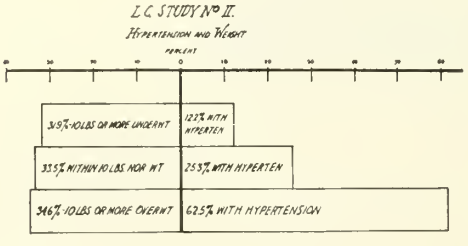
2. *Hypertension.*

Thirteen percent of the office workers, 9.1 percent of the factory workers, and 29.7 percent of the dispatchers had frank hypertension.

3. Comparing here the pulse pressure of the factory workers, and dispatchers, 28.8 percent of the former and 58.6 percent of the latter had pulse pressures in excess of 50 m.m.

True enough the numbers examined were not similar (165 dispatchers and 1000 workers) still the percentages of significant fiindings were impressive enough to be more than suggestive. It is known that train dispatchers die prematurely in spite of the fact that they are selected on the basis of "durable and rugged qualifications". Here, the cause or causes for the high mortality from circulatory diseases must be other than those accepted up to the present.

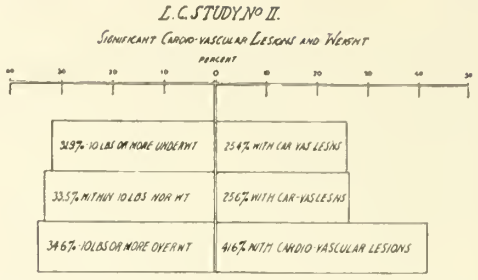
To return now to the results of the examination of the office and factory workers where periodic examinations reveal much of value. Of 1000 men of ages 25 years and under 65 years in clerical occupations, 836 possessed physical defects which were leading to or would eventually lead to serious physical handicap. Now what were the apparent predisposing causes of heart disease



found in these workers? One and six-tenths percent had albuminuria; 1.9 percent had glycosuria; 12.9 percent had significant high blood pressure; 42 percent were overweight—20 pounds or more. (Plate II.)

Among the men over 40, those overweight by 20 pounds or more, showed heart defect in three-fourths of the cases and 50 percent of these had hypertension. (Plate III.)

Of the 1000 machine and hand tool operators,

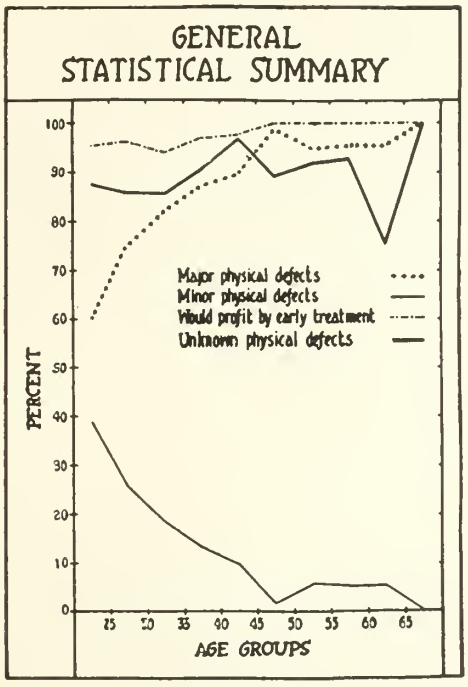


4.4 percent had albuminuria; 0.2 percent had glycosuria; 9.1 percent had hypertension, and 34.6 per cent were overweight, among whom heart disease, and high blood pressure again were conspicuously more common than for those of normal weight. There were in this group, fewer who showed high blood pressure, fewer overweight, and fewer found to have heart defects. They have less responsibility, but greater physical demands than the clerical workers.

We have here a considerable number of individuals at work oblivious to the fact that they are harboring defects, many remediable, which might shorten their lives or render them prematurely old. (Plate IV.)

However, the prevention of further inroads of predisposing factors on the cardio-vascular system is not a simple matter. General hygienic care for all, as for example in the treatment of tuberculosis, will not produce results because heart disease is not due to one factor but to a multiplicity of causes, all of which may operate along the lines of wearing out the machine. If we are to successfully cope with the mounting tide of premature deaths from heart disease, it is necessary to have a different clinical set up than is usually seen in the heart clinics as they are conducted in the the various centers. Examining large numbers of heart victims, classifying them, dosing them with heart tonics, telling them to "be careful and not work hard and take lots of rest, and return in a week", will in no wise affect the problem. Unless the clinicians are experienced doctors who understand well the treatment of early diabetes, beginning kidney disease, metabolic disorders, dietetics, when to refer patients to reliable, sensible, and intelligent psychiatrists, and who will devote the necessary time required to each patient, the results will be most discouraging. It therefore follows that, except for his diagnostic skill, there must indeed be very few "heart specialists", if there really exists such a specialty.

As an example, consider the subject of hypertension. Very little is known concerning its cause. Still it is not at all unusual to find young, enthusiastic clinicians ridiculously dieting such patents, relegating them to a life of unwarranted rest, during which they do nothing but worry. Yet worry and emotional strain have always been considered probably the most important causative



factors in the production of high blood pressure. The same applies to diabetes, paroxysmal tachycardia and exopthalmic goitre. The profession has been somewhat reluctant to recognize this factor, but greater stress must be laid on this in the future, and the well-balanced mental hygienist must play an important part in the control of these disorders. The prevention and control of circulatory diseases do not require, and I for one thought it did, special clinics and set ups. The medical clinics will minister to their needs just as well if well trained physical diagnosticians, dietitians, psychiatrists, technicians, nurses, and social workers are in attendance, and if their services are enlisted. The two latter groups must assist in properly placing cardiacs and potential victims in appropriate institutions, convenient living conditions, and suitable industries. The forces must work as a unit. There must not be the need of rushing patients along. This type of endeavor requires thought, careful consideration, and sound judgment, without which little will be accomplished.

CONCLUSIONS

1. The control of advancing mortality from diseases of the cardio-vascular system, must be directed along lines heretofore neglected. The mortality of the younger age groups is decreasing. The mortality of the middle age group is mounting.
2. There is strong evidence that organic impairment results from prolonged overwhelming mental strain.
3. The organic cardio-vascular disorders found on examining 165 train dispatchers, as well as 1000 factory workers and office workers, is referred to, as an argument to direct preventive work in somewhat different manner.
4. The need of dependable mental hygienists in the field of cardiology is stressed.
5. "Heart specialists", unless they are all around experienced physicians, cannot effectively direct the clinical course of cardiac or potential cardiac patients, because of the many factors which must be considered. Heart disease is due to a multiplicity of causes.
6. Special heart clinics, except for diagnostic reasons, are not essential. A well-balanced medical clinic may serve the purpose.
7. The propaganda for control of cadiavascular disease should consist of educational matters, but it should treat only of those factors of which we can speak with confidence as causative agents.

19 W. EIGHTH STREET.

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DISCUSSION

F. P. ALLEN, M.D., Cincinnati: I consider Dr. Benjamin's discussion of great value, in that he has presented some modern ideas with reference to causative factors making for an increase in the prevalence of cardio-vascular diseases. Not until the last few years have the medical profession and public health workers given very much attention to the increasingly high mortality rates from these diseases. It is therefore especially timely that a subject such as this be discussed from the public health point of view.

In the general population with ages under 40, the past two decades have witnessed a declining trend in mortality from the cardio-vascular diseases. From the ages 40 to 60 there has been very little variation in the trend, except for a tendency in recent years for an increase around 50 to 60 years. Beyond the latter age the mortality trend is rising very rapidly. While our efforts in the control of heart disease are needed through the entire span of life, it is evident that these efforts should be greatest with the adult population, and especially with the age group between 30 and 50 years.

Viewed from the public health standpoint, the heart disease problem in the last analysis must be dealt with through individuals. In modern public health practices many phases of this work have crowded the practicing physician into the background. In the control of cardio-vascular disease, however, the practicing physician must take a most active part. We have no immunizing agents, nor will isolation and other procedures which may be applied to the group in the case of certain contagious diseases, solve the heart disease problem.

As an approach, however, much can be done through the group. This approach will be to encourage larger numbers of persons to undergo periodic physical examinations. Our largest insurance companies are finding it of mutual advan-

tage to policy holders and themselves to encourage periodic physical examinations. By this means insurance companies are finding that many diseases can be discovered in their incipiency, when there are the greatest hopes for cure or arresting disease progress.

The Heart Council studies referred to by the essayist reveal a high incidence of physical defects which were leading to or would eventually lead to serious physical handicaps. Nearly one-third (33.5%) of the two groups mentioned was found with significant cardio-vascular defects. Over three-fourths of all the men possessed defects unknown to them, or at least they did not admit knowing of the defects at the time of examination. Over 80 per cent of these men would, in the estimate of the examining physicians, profit by early medical or dental care.

We can at least surmise on the basis of the findings derived in these studies cited by Dr. Benjamin, that a large amount of physical impairment exists in the population at large and that the cardio-vascular system is commonly involved. What means have we for discovering for treatment early lesions of the cardio-vascular system, other than the careful physical examination repeated at intervals of six months to a year? Will there not be a more hopeful outlook in the control of our leading cause of death, when the public more generally avails itself of this means?

Food Allergy*

KARL D. FIGLEY, M.D., Toledo, Ohio

DEFINITION

By food allergy is meant specific sensitization to a certain food or foods. The active principle in the food to which hypersensitiveness is established in the body cells is probably a protein. This active principle is called an "allergen" or "atopen." After gaining entrance into the body, it unites with its specific antibody or reagin, thereby liberating a toxic, histamine-like substance. This substance exerts its effect on various body tissues, resulting either in smooth muscle spasm, edema or a combination of both. The symptoms thus brought about constitute the symptom-complex known as food allergy.

FREQUENCY OF FOOD ALLERGY

Specific sensitivity to certain foods has always existed and has long been recognized by the name of idiosyncrasy. It is rather common knowledge that certain persons are poisoned by eating shellfish and that others develop hives from eating strawberries. However, it is only recently that the wide-spread, all-embracing nature of food allergy has been appreciated—and this appreciation is still in its infancy. Largely through the writings of Rowe[1,2,3,4] and Vaughan[5,6,7,8] in this country, together with the work of a few men in France[9], we are learning how prevalent this process is in the causation of various illnesses.

Most authors give the incidence of allergy as a whole—i.e., hay fever, asthma, eczema, etc., as about 3 per cent of the population. However, Rowe thinks this figure is far too low and in a study of 400 unselected university students and nurses, was able to obtain evidence pointing to some degree of food sensitiveness in nearly 30 per cent. Just what the true incidence of food allergy may be is impossible to state. At all events, it is much more frequent than is now generally appreciated.

HEREDITY

Why is food allergy restricted to certain individuals? An illustration by Vaughan may be quoted. "If, following a banquet, most of the participants become ill, something was wrong with the food. If, on the other hand, with all eating the same food only one individual becomes ill, something was probably wrong with that individual. The first was an instance of food poisoning, the second of food allergy." The answer to the question as to the selectiveness of allergy, lies in its hereditary nature. To my mind there is no doubt that every case of allergy represents an inherited tendency. Figures from various authors give the incidence of a positive family history as from 50 to 60 per cent. In my experience, the incidence is much nearer 90 per cent. Perhaps at the first visit, the patient cannot recall any history of allergic manifestation in his immediate family or his ancestors, but by the second visit he has often brushed up on his family history to the extent of being able to report several instances. Not only does an allergic heredity predispose to the disease, but also in some measure it determines the age at which the individual will manifest symptoms. Where the inheritance is bilateral (through both father and mother) 89 per cent of the children are apt to develop allergic symptoms in their first 10 years of life. Where the inheritance is unilateral, 31 per cent are apt to develop symptoms in their first 10 years. It is estimated that nearly three-fourths of all children with bilateral allergic inheritance will eventually develop the disease, while about one-half of those with unilateral inheritance will do likewise.

It should be distinctly understood that what is inherited is simply the tendency to become hypersensitive. One does not inherit a specific sensitization to some food or pollen, but simply the susceptibility of becoming sensitized. Also, the particular variety of allergic manifestation is not usually transmitted. Thus a father with pollen hayfever may have three children. One develops eczema early in life from milk sensitiveness, another develops asthma from a pet rabbit, while the third never shows any allergic trait. How-

ever, the off-spring of this third child, may in their turn, manifest allergic tendencies.

Occasionally, the family tendency to food sensitiveness is quite pronounced. Thus a lady of 57 is found sensitive to pork, berries, eggplant and potato. Her maternal grandmother had hives and asthma. Her father was sensitive to egg, corn and ragweed. Her brother gets hives from berries and her daughter is affected by eggs and corn.

It has recently been shown that food sensitization takes place in utero,[10] the allergens passing from the mother's blood, through the placenta, thus sensitizing the infant, so that it manifests an allergic response to some food the first time it is given that food. Intrauterine sensitization also explains the occurrence of eczema while the infant is still being breast-fed. An infant of 6½ months was seen with severe eczema. This had been present from birth and had become much worse when breast-feeding was stopped and the child given a mixture of cows-milk and cereal. Skin tests gave definite reactions to wheat, milk and egg, although the child had never been given any egg. The eczema cleared up following the avoidance of wheat and milk. The egg-sensitiveness and probably that to the other foods, was undoubtedly established in-utero.

MANIFESTATIONS OF FOOD ALLERGY

In the adult, food allergy manifests itself as gastro-intestinal disturbances, bronchial asthma, perennial hayfever, eczema, urticaria, angioneurotic edema, allergic migrane and other less common manifesations referred to the urinary bladder, uterus, joints and nervous system. (Table 1.)

The gastro-intestinal disurbances that may be produced by food allergy are numerous. They include upper abdominal symptoms simulating cholecystitis or ulcer, and lower abdominal symptoms like those of appendicitis or colonic disease. In their recent work "Diseases of the Gall Bladder and Bile Ducts," Graham, Cole, Copher and Moore[11] place food allergy third in their list of differential diagnoses of cholecystitis. Gastro-intestinal food allergy is usually characterized by epigastric distension, flatulence, often nausea and vomiting, cramping, constipation or diarrhea which is often of the mucous colitis type. In these cases there is frequently a history of hematemesis or melena. This bleeding, however, is quite consistent with the mucosal congestion brought about by the allergic reaction.

TABLE 1

SYMPTOMS OF FOOD ALLERGY

GASTRO-INTESTINAL:	
Canker sores	Intestinal cramps
Distension	Mucous colitis
Belching	Diarrhea
Epigastric heaviness	Constipation
Pyrosis	Upper right quadrant pain
Nausea	Lower abdominal pain
Vomiting	Ulcer type of pain
	Pruritis Ani
BRONCHIAL ASTHMA	
ECZEMA, URTICARIA, ANGIONEUROTIC EDEMA	
ALLERGIC MIGRANE	
PERENNIAL HAY FEVER	
ANTERMITTENT HYDRARTHOSIS	
DYSMENORRHEA	
BLADDER ALLERGY	
HENOCH'S PURPURA	

Rarely is one body tissue or tract alone involved in the allergic reaction. Usually there are symptoms involving various parts of the body such as the gastro-intestinal tract, skin and respiratory tracts. Thus a young lady of 26 consulted me for recurring attacks of hives which had annoyed her for some years. Inquiry elicited a history of vague digestive disturbances characterized by cramps, bloating, constipation. Appendectomy had failed to give relief. In addition, this patient had had many nasal treatments for recurrent colds, which were in reality the symptoms of perennial hayfever. Lastly, for some years she had shunned social affairs because of the condition of her scalp which was covered with scales of dandruff. It was found that she was sensitive to wheat and milk. Her symptoms completely disappeared on eliminating these foods from her diet. An attempt to immunize her by injections of wheat extract caused recurrences of her hives and digestive symptoms with one drop of a 1-10,000 solution.

A woman aged 34, had three attacks of angioneurotic edema in the past year, with swelling of the face, eyes, ears and hands, accompanied by generalized urticaria. With these attacks, there were terrific frontal headaches, nausea and vomiting, diarrhea for several days and temperature elevation. The tendency to loose bowels, cramps and diarrhea dated back to the age of 19. In the past five years, the patient had mild attacks of "rose-colds" during June and July. The patient's mother also had so-called "rose" hayfever. The appendix had been removed at the age of 20 and a later exploratory operation failed to account for the abdominal symptoms. It was found that this patient was sensitized to wheat, milk, beef, tomatoe, eggplant and grass pollen. A violent recurrence of all her symptoms followed an intracutaneous test with a dilute milk extract, and the same occurred from testing with wheat. Elimination of the various food allergens relieved all symptoms.

A woman aged 34, for ten years had recurrent attacks of loose bowels with occasional bloody stools, abdominal cramps and flatulence. In recent years there developed a spasmodic unproductive cough, dysmenorrhea, urinary frequency and occasional large purpuric ecchymoses on the trunk and limbs. For the past three summers she apparently had seasonal hayfever. At all times there was a slight temperature elevation. The patient had been hospitalized several times and had all sorts of laboratory and *X*-ray examinations with normal findings. Diagnoses of Achylia gastrica, spastic colitis, nervous indigestion and tuberculous enteritis had been made. The appendix, gall-bladder and uterus had been removed. The patient felt that lettuce, tomatoes and other raw vegetables made her colitis much worse but even a smooth diet did not relieve her abdominal symptoms. Eventually it was found that she was sensitized to wheat, rye, milk, beef and cottonseed. She was not found sensitive to

TABLE 2
POSITIVE SKIN REACTIONS IN 11,443 CASES OF ALLERGY. (Alexander)

Allergic Manifestation	No. Observers	No. Cases	No. Positive Reactions	% Positive Reactions
Hay Fever	9	4381	4076	93.2
Vasomotor Rhinitis	8	1020	568	55.7
Eczema (infant and adult)	10	775	408	52.7
Bronchial Asthma	13	4809	2536	52.7
Gastro-Intestinal Al.	4	460	122	26.5

any vegetables or pollens. Her symptoms were chiefly due to the cereals and milk, and her summer hayfever symptoms were due to mayonnaise made from cottonseed oil and potato chips cooked in this oil. Since eliminating these various foods from her diet, her abdominal symptoms, cough and hayfever have disappeared and she can eat all vegetables without ill-effect. This patient's mother and grandmother had asthma, her own two children as yet manifest no allergic traits.

As I look back over my case-records of several years ago, I run across the familiar terms, "nervous indigestion," "spastic colitis," "mucous colitis," "chronic intestinal invalid." How many of these were cases of food allergy and still going the rounds seeking relief, I know not. I strongly urge those of you who are seeing such patients to consider the possibility of food allergy in these cases, particularly if there is a family history of allergic tendencies.

IN CHILDHOOD

Some special mention should be made of food allergy as it pertains to infancy and childhood. It may manifest itself as colic, feeding difficulties, cyclic vomiting, eczema, urticaria, bronchial asthma, chronic cough, bronchitis, recurrent head colds and allergic toxemia. Food allergy is especially common in infancy. As age increases, tolerance for various foods gradually improves in most cases and the colic, indigestion and dermatitis which are so frequently due to food allergy usually disappear. However, it is my opinion that the general impression that food allergy is usually outgrown during the first decade, is erroneous. The original manifestations such as eczema or asthma may disappear but the potential susceptibility of food sensitization remains only to reappear in later life as some other allergic manifestation. It is rare indeed that the adult asthmatic does not give a history of eczema or hives in childhood. Balyeat[12] has recently shown that the cyclic vomiting of childhood often is replaced by allergic migraine in later life.

With regard to childhood eczema, I firmly believe that this is primarily due to specific food sensitization, especially if there be a positive family history of allergy. I realize that my pediatric friends may not agree with this statement but increasing experiences of my own and other allergists all point in this direction. Specific antibodies can be demonstrated by the method of passive transfer in the majority of cases of childhood eczema and absolute elimination of the causative allergens will serve to clear them up. It is true that contact substances later come to play a part in the perpetuation of the dermatitis but underlying it all is the original factor of food sensitization. The foods most often responsible are those which the child is first fed and which he most commonly eats, namely, cereals, milk and egg. Incomplete elimination from the diet is the most frequent cause for failure to completely relieve the eczema. Thus an infant was found sensitive to wheat and cow's milk. The mother very thoroughly avoided these foods in the diet but the eczema persisted. Finally it was found that Vitavose, a wheat-germ preparation was being given. This solved the problem.

Childhood asthma almost invariably has its genesis in food sensitization. The usual history is that the child had eczema until the age of one or two years. There is a positive family history of allergy on one or both sides. From early life the child was subject to recurring head colds, so-called, which appeared quickly and disappeared after a matter of hours or at the most a day or two. There were frequent attacks of bronchitis, often accompanied by fever, vomiting and digestive upsets. Perhaps these attacks had even been called bronchopneumonia, but a peculiar kind of pneumonia where the child had a fever of 103 one day and was out doors playing the next day. Eventually, typical asthmatic seizures manifest themselves. These may be more frequent in the winter months and appear to be the resuit of infectious colds. Probably the tonsils and adenoids are removed or some nasal operation done, but with little benefit. Or the asthmatic attacks may be more frequent in the summer and seem to

TABLE 3

FOODS RESPONSIBLE FOR NASAL ALLERGY IN 95 CASES RECORDED. (Eyermann)

Wheat	30	Chicken	2
Egg	24	Cabbage	2
Milk	17	Cucumber	2
Chocolate	15	Rice	2
String bean	12	Cherry	1
Potato	11	Raspberry	1
Pea	9	Blackberry	1
Salmon	8	Pineapple	1
Tomato	7	Grapefruit	1
Onion	6	Orange	1
Cantaloupe	6	Ginger	1
Beef	6	Green pepper	1
Corn	5	Lettuce	1
Pecan	5	Lima bean	1
Asparagus	4	Radish	1
Apple	4	Garlic	1
Grape	3	Rye	1
Peanut	3	Veal	1
Pork	3	Walnut	1
Spinach	3	Rhubarb	1
Almonds	3	Chicory	1
Peach	2	Mint	1
Strawberry	2	Carrot	1
Watermelon	2	Oat	1
Sweet Potato	2		

be dependent on pollens. Sooner or later it will be found that all these symptoms—the eczema, recurrent colds and bronchitis, digestive upsets and finally the asthma, were dependent on some primary food sensitization. Non-specific factors such as infection may play a part in the picture. Vaughan has shown convincingly that if the allergic equilibrium is upset, non-specific factors become operative, but cease to function when the causative allergen is eliminated. Two cases in point come to mind. They are boys of about eight who have had asthma from early life. I found they both reacted strongly to pollens and treated them religiously a year ago with pollen extracts. Later, I discovered they were sensitized to certain foods, and by eliminating these, they passed through the last pollen season very comfortably without any pollen treatment. Very frequently, hayfever patients or pollen asthmatics can tolerate large amounts of pollen if only their underlying food sensitization be corrected. They can tolerate the food alone or the pollen alone, but not both at the same time.

REASONS FOR FAILURE TO RECOGNIZE FOOD ALLERGY

Why is not food allergy more often recognized and given the place it deserves in the causation of disease? The reason is two-fold: first, the failure of the skin test to always point out the causative allergen, and second, incomplete attempts at food avoidance.

SKIN TESTS

When the skin test was first proposed, it was assumed that all truly allergic cases should give positive reactions. Experience has shown this not to be the case, consequently, interest in skin-testing has lagged with many men who used it only occasionally. There are so many factors that enter into skin testing that it is not the simple matter it was once thought to be. Thus, allegery is a localized process and only certain organs of the body manifest it. It may show itself in the skin, respiratory tract or gastro-intestinal tract but in not all at the same time. The skin reacts more frequently to testing in young individuals and is notoriously refractive in later life. Certain parts of the skin react better than others, thus the back and trunk react best, the skin of the thigh next and that of the forearm least of all. Intracutaneous testing is far more informative than scratch testing, and because of its delicacy often gives false positive reactions.

Proper materials have everything to do with the success of skin testing, and until very recently these have been almost impossible to obtain. And finally, proper interpretation of reactions is quite as important as proper interpretation of radiographs. A delayed reaction which is of great practical importance, may pass unnoticed by the inexperienced physican. As the accompanying table from Alexander[13] shows, (Table 2) positive skin reactions occur with varying frequency, according to the allergic manifestation. They occur least often with gastro-intestinal allergy and are so unreliable in urticaria and angio-neurotic edema that no figures are given. Although food tests as performed today are not over 50 per cent accurate diagnostically, they make the best point of departure at the beginning of the study, for when positive they provide a definite starting point in the formulation of the diet. If their use decreases the amount of subsequent necessary investigation by 50 per cent or even 25 per cent, they are well worth employing.

Incomplete attempts at food avoidance constitute the second great reason for failure in the diagnosis and treatment of food allergy. A wheat-sensitive patient recently had a recurrence of his urticaria from drinking home-brewed beer made in part from wheat. Ordinary rye bread contains 40 per cent wheat flour. The patient must know that Ovaltine and certain baking powders contain dried egg, that most olive oil is adulterated with cottonseed oil, that black pepper is often adulterated with buckwheat, and that milk sensitiveness means the avoidance of all dairy products including oleomargarine. Only by careful attention to detail and scrupulous vigilance can the common food allergens be eliminated.

FOODS RESPONSIBLE FOR ALLERGY

Various authorities give lists of foods differing in their frequency as causes of allergy, according to the experience of the author. Naturally, the frequency will vary with geographical distribution, racial food habits, the allergic symptoms

TABLE 4

"ELIMINATION DIETS FOR THE TREATMENT OF FOOD ALLERGY." (Rowe)

	Diet No. 1	Diet No. 2	Diet No. 3	Diet No. 4	Diet No. 5
Cereal	rice (natural)	corn	rice tapioca	rice rye	milk alone
Bread	none	corn pone	none	rye-rice Ry-crisp	for the
Meat or fish	lamb	bacon chicken	beef	cod, halibut and white-fish	test period
Vegetables	lettuce spinach carrots	squash asparagus peas artichokes	tomatoes celery string beans	lettuce carrots peas beets	2- quarts a day
Fruits and jams and fruit drinks	lemon pears peaches	pineapple apricot prunes	grapefruit pears peaches	pineapple apricots pears	
Miscellaneous	sugar olive oil salt olives (unstuffed) maple syrup gelatine	sugar mazola oil salt	sugar Wesson oil salt gelatine maple syrup	sugar olive oil salt olives (unstuffed)	

encountered, and the age of the patient. All authorities agree, however, that the foods most commonly responsible for allergic symptoms are those most frequently eaten. In this country, wheat, egg and milk are by far the most frequent causes. In Rowe's experience, wheat, egg, milk, chocolate, cabbage, orange and potato were found to be the most common foods producing allergic manifestation. In my own experience, beans and nuts should be added to this list. In the East, sea food is an important addition. The accompanying table by Eyermann,[14] shows the foods responsible in 95 cases of nasal allergy.

DIAGNOSIS

A long step toward the diagnosis has been made when the physician considers the possibility of food allergy when confronted with a patient evidencing any or several of the conditions previously enumerated that may be caused by food sensitization. Food allergy should be thought of when symptoms exist which cannot be explained by any examination or tests. This is especially true of patients who have family or personal histories suggestive of allergy. I cannot emphasize too strongly the importance of a family history of allergy. One may have to dig to bring out the salient points; the result will often be gratifying. Only recently I saw a man who has had a most stubborn vaso-motor rhinitis for months. He repeatedly asserted that his family history was negative for allergy. Eventually he recalled that his mother had prostrating "sick headaches" from cucumbers. This showed the inherited allergic tendency and by following this lead, the foods causing his vaso-motor rhinitis were determined.

Proper and thorough skin testing is the first step in searching for the causative allergens. In infants and younger persons, scratch-testing is usually satisfactory. In older persons, intradermal testing is necessary. This often gives false positive reactions, but because of its delicacy, is indispensable. Vaughan has emphasized the value of the delayed reaction. This consists of a reddened area with possible slight induration which appears at the site of the test—either scratch or intracutaneous, in from six to twenty-four hours. This delayed reaction is quite similar in appearance to the Schick test. In cases of food allergy, I find the delayed reaction almost more valuable, than the direct reaction. In a case of persistent bronchial asthma in a man of 50, all direct intracutaneous tests were completely negative but a delayed reaction to rye pointed to the cause of the trouble—the patient being a confirmed eater of rye bread.

The Prausnitz-Küstner method of indirect skin-testing—so-called "passive sensitization" method is also of value. This consists of temporarily sensitizing several sites of the skin of a normal person, with small intradermal injections of the allergic patient's serum. This serum contains antibodies or reagins which will passively sensitize normal skin in a localized area for a period of several weeks. After two to three days, when all evidences of irritation have disappeared from this passive transfer, the normal substitute is tested intracutaneously with the suspected food allergens, at the sites previously passively sensitized. This method is of value where the patient's skin is so abnormal from eczema, ichthyosis, urticaria, etc., that direct testing is impossible. It is also of value in asthmatics who are saturated with adrenalin, in infants and very small children whose parents are opposed to direct tests on the child, and as a means of check-

TABLE 5

THE BIOLOGICAL GROUPING OF THE COMMONER VEGETABLE FOODS

GRAMINAE	POMACEAE
Wheat	Apple
Rye	Pear
Barley	
Oat	DRUPACEAE
Rice	Almond
Corn	Plum, prune
	Cherry
LILLACEAE	Apricot
Onion	Peach
Garlic	
Asparagus	LEGUMINOSAE
	Peas
POLYGONACEAE	Beans
Buckwheat	Lentil
Rhubarb	Peanut
JUGLANDACEAE	RUTACEAE
Black walnut	Lemon
English walnut	Orange
Pecan	Grapefruit
Hickory	
	UMBELLIFERAE
CHENOPODIACEAE	Carrot
Spinach	Parsnip
Beet	Parsley
Swiss chard	Celery
CRUCIFERAE	SOLANACEAE
Radish	Potato
Turnip	Egg plant
Rutabaga	Tomato
Mustard	
Cabbage	CUCURBITACEAE
Kale	Pumpkin
Brussels Sprouts	The squashes
Kohlrabi	The melons
Cauliflower	Cucumber (pickles)
Broccoli	
	COMPOSITAE
ROSACEAE	Salsify (oyster plant)
Blackberry	Chickory
Raspberry	Endive
Strawberry	

ing the significance of several direct positive tests.

Of equal or perhaps greater importance in the diagnosis of food allergy than skin testing, is the employment of the Elimination Diet. This addition to our armamentarium was first advocated by Rowe.[2] Others, including Dale and Thornburgh,[15] and Vaughan have advocated trial diets but to Rowe belongs the credit of first calling attention to its value in diagnosis and treatment. (Table 4.) Rowe's elimination diets were worked out by compiling a list of foods most frequently causing allergic manifestations. These foods then were avoided in making up his elimination diets—only those foods being included which infrequently caused trouble. Rowe has constantly stressed the necessity of keeping the patient on one of these trial diets for at least two weeks before switching to another diet. It may take this long for the patient's symptoms to clear up, following the last ingestion of the offending food allergen..

Vaughan[6] has recently helped to simplify the problem by pointing out that clinical reactions to foods may depend in part on their biologic relationship. (Table 5.) He has shown that the use of a testing extract prepared from the various members of the same botanical group of foods might give a positive reaction when the individual food allergens give negative reactions. In other words, he fortifies the similar group antigenic proteins by combining them. This biologic grouping has been helpful in several instances by casting suspicion on negatively reacting members of a group, in which only a single positive reactor had been found. Thus the skin may react only to tomato and still the patient be clinically sensitized to eggplant or potato, members of the same group. Rowe's elimination diets are not based on the scheme of biologic grouping and they occasionally need revising from this viewpoint.

One other method of diet trial is available in the diagnosis of food allergy and that is the keeping of a food diary as proposed by Vaughan.[8] The patient is asked to carefully record on a prepared sheet of paper, all the foods that he eats for a certain number of weeks. By a series of checks or crosses, one can see at a glance which foods the patient eats most often and those eaten infrequently. The food diary is of most value in cases where the patient has allergic manifestations at intervals such as migrane or urticarial attacks. Here they may be due to a food eaten infrequently or to the cumulative effect of foods eaten daily. In either case, the food diary will help to detect. On the other hand, where the symptoms are of frequent or daily occurrence, the elimination diet finds its greatest usefulness.

TREATMENT

The treatment of food allergy consists in the detection of the causative allergens and their elimination from the diet. In the case of infants and children, tolerance is gradually acquired in most instances after a period of a year or two, so that the previously allergenic food can at least be taken in moderation. Food allergy is usually a quantitative affair. The patient often finds he can tolerate small amounts of the offending food but that larger amounts cause symptoms. Again, the antigenic protein may be so changed by heat as to render it non-allergenic. This is true particularly of cow's milk, which cannot be taken raw but may be tolerated as evaporated milk, dried milk or denatured milk. At times wheat can be tolerated in the form of thoroughly toasted bread. Often vegetables and fruits may be eaten cooked but not in their raw form.

Occasionally food tolerance is never acquired. This is especially true of egg and nuts. I recently saw a young lady of 27 who could never eat the slightest amount of food containing egg. Not long ago she entered the house while her mother was serving refreshments for her bridge

club. The young lady promptly developed asthma from the odor of egg in the cake being served.

Desensitization to foods by the hypodermic administration of food extracts is nearly always unsatisfactory, and not worth the effort. It may be quite dangerous, especially in egg-sensitive cases. I have tried this method in a few cases of wheat sensitiveness and have usually only succeeded in provoking unpleasant recurrences of symptoms.

Oral desensitization by the feeding of gradually increasing amounts of the offending food may be tried. This is only necessary of course, in cases of wheat, milk or egg sensitiveness. It should never be commenced until after a period of complete elimination lasting several weeks. Like the injection method, oral desensitization is usually unsatisfactory. The best treatment for food allergy is complete avoidance for a period of months, or so long as the allergen causes a recurrence of symptoms.

316 MICHIGAN ST.

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Cosmetic Claims Being Watched by U. S. Bureau

Tooth pastes, face creams, hair dressings, shaving soaps and other cosmetics become subject to the provisons of the pure food and drugs law when claims are made that such products can cure, prevent or mitigate diseases, according to an announcement by the Food and Drug Administration of the Department of Agriculture.

The Food and Drug Administration has noted a recent material increase in the number of manufacturers who are labeling cosmetics with claims for the prevention or cure of disease, thereby rendering the goods subject to action under the Federal Food and Drugs Act, according to W. G. Campbell, director of regulatory work of the department.

"Tooth pastes, face creams, hair dressings, shaving soaps, and other cosmetics, normally not to be classed as drugs, become subject to regulation under the national food and drug law only when they are labeled with claims for the prevention, mitigation, or cure of disease," says Mr. Campbell.

"Tooth pastes are sometimes labeled as antiseptics or as cures or preventives of diseases of the mouth. These, when so labeled, if shipped interstate, become subject to Federal regulation. Some manufacturers represent face creams as having power to cure pimples and other skin diseases; others label hair dressings as hair restorers, and shaving soaps as antiseptics or destroyers of disease germs. Articles so labeled are subject to action under the Food and Drugs Act, since technically they then become drugs.

"The law defines a drug as any substance or mixture of substances intended to be used for the cure, mitigation or prevention of disease of man or other animals. Some articles, such as quinine tablets, primarily are medicines and have no use other than as medicines. But any substance, including cosmetics and dentifrices, becomes a drug under the law when it is offered for the treatment or prevention of disease," says Mr. Campbell.

"When manufacturers of articles that would ordinarily be classed as cosmetics label their preparations with curative claims, thus classifying their goods as drugs, they become subject to action under the law. Labels on cosmetics must be strictly truthful, otherwise the preparations will be subject to action.

"Reliable dental opinion holds that no tooth paste, regardless of its composition, can truthfully be represented as a cure or a preventive of pyorrhea and certain other oral diseases. Physicians regard only such preparations as are tonics for other parts of the body as tonics for the hair. Pimples may be a symptom or the result of a variety of diseases, many of them serious, for which face creams do not constitute adequate treatment.

"So long as cosmetics are labeled solely as cleansing agents, beauty enhancers, etc., they will not become subject to action under the Federal Food and Drugs Act, but if manufacturers label them as drugs, they must accept the responsibility for marketing the commodities in strict compliance with the requirements of the national law."

The President's Page

A Personal Communication to the Membership from

H. M. Platter, M.D., Columbus, Ohio

May I request that this communication be considered a personal appeal to each member?

Our problems have multiplied because of uncertain economic conditions. With traditional high purpose we have carried on and served to the best of our ability for the health and welfare of our patients and of our communities. We have been, and will continue to be confronted by economic and social problems. Through faithful and self-sacrificing service on the part of our officers, the Council, committees and executive staff, which have been supported by splendid cooperation of the officers, committees and membership itself in component county societies, we have been able to meet most of the problems presented and are prepared to meet more serious questions in the future.

Organized medicine should be proud of its accomplishments during the year just closing. This was made possible through united, harmonious purposes and effective cooperation. I desire to extend congratulations and appreciation to the officers and committees of the county societies and the State Association and, particularly, to the membership at large whose interest and support has made these accomplishments possible.

We must now consider our duties and responsibilities for the coming year and organize to repeal forces which are at work to complete the socialization of medicine. Sudden radical changes are imminent. It is especially vital, therefore, that we stand together, a united virile organization, in order that scientific medicine may be preserved. The organization must be strengthened to preserve and defend scientific independence and economic stability so that we may discharge our major function of greatest public service.

Our membership has been passing through an exceedingly difficult period indeed. Our difficulties will probably increase during the coming months. Both protection and self-preservation may be urged as a reason why we must all enlist in a common cause, for as individuals we might be destroyed by a sudden change in the social stream, but together we can sustain and preserve the major principles and the time-tested ethics of our profession.

Propaganda and strong social forces are seeking to mechanize medical practice. Social theorists are planning to use the findings of the five-year inquiry by the National Committee on the Costs of Medical Care (regardless of the complete report) as propaganda for governmental or communistic medicine. Institutions and organizations dependent, primarily, on medical service and medical advice for their existence which have been aided by some of our members in service or influence, now threaten to become, or have become, unfair competitors with physicians in private practice.

We are committed, of course, to the support of major elements for public protection such as adequate public health administration devoted to control of community sanitation, control of communicable diseases, enforcement of quarantine, protection of pure water supplies, foods and milk, sewage disposal and public health education. It is our duty, however, to oppose the engrafting into public health administration of so-called welfare activities, of organizations which encroach upon the practice of medicine and unfairly compete with our own members.

For years our policies and principles have been clearly defined and logically developed. We must adhere to them—yes, fight for them—or be swept aside in a course of social experimentation.

My personal appeal is that each member pay his membership dues in his county

society and the State Association for 1933 promptly. Membership dues in our State Association are due in advance before January 1st. Annual per capita dues in the State Association are five dollars ($5.00) which are deducted from the total dues in the academy or county society and transmitted by the secretary-treasurer of the local unit to the State Association headquarters. *Continuous good standing depends on the receipt of your dues in the State Association at our headquarters office before January 1st, 1933.* Equally important I would urge every possible effort be made to enlist into membership every eligible non-member in each county.

In addition to the many benefits of local membership, let me briefly summarize a few of the general benefits of membership in our State Association as follows:

(1) It is an assurance of the physician's standing in his community before the public, the law and the profession.

(2) It helps to maintain organization machinery for the service of the members. In other words, it is a central clearing house of valuable information.

(3) It makes possible the publication of the *Ohio State Medical Journal* which is a consecutive record of scientific, economic, social, legal and legislative developments of direct interest to every practitioner.

(4) It provides the means for contact with state and federal departments, for impressing on the executive, judicial and legislative branches of the government the concerted medical viewpoint.

(5) It provides the means for cooperation with other state-wide and national groups interested in common problems of public health and professional practice.

(6) It affords protection against unwarranted mal-practice suits, a service which makes unpopular all efforts or attempts to "swindle" physicians.

(7) It makes possible the maintenance of Association bureaus and committee activities for the benefit of all.

(8) It affords a unanimity of effort in all endeavors, particularly against the proponents of paternalism, state medicine, radicalism and cultism.

The State Association officers, the Council and committees are deeply appreciative of your support and cooperation. We also solicit your comments, suggestions and construetive criticism.

Finally, permit me to extend to each member of medical organization in Ohio sincere best wishes for happiness in the coming holiday season.

State Hospital Doctors Meet

The Ohio State Hospital Association Physicians held their annual conference October 27 and 28, at the Dayton State Hospital. Among those who addressed the conference were Dr. I. A. Bradley, Columbus; Dr. J. F. Bateman, Cincinnati; Dr. Serge Androp, Gallipolis; Dr. B. A. Williams, Cincinnati; Dr. E. L. Hooper, Dayton; Dr. M. N. Fowler, Athens; Dr. A. T. Hopwood, Orient; Dr. H. P. Potter, Toledo; Dr. N. W. Kaiser, Toledo, and Dr. H. H. Fockler, Columbus.

At a business session, the following officers were elected: President, Dr. L. L. Poage, Dayton; vice president, Dr. Beatrice Postle, Columbus; secretary-treasurer, Dr. A. A. Petty, Dayton. It was decided to hold next year's meeting at the Massillon State Hospital.

Medical Alumni Hold Reunion at Ohio State University

Several hundred alumni of the College of Medicine, Ohio State University, attended the reunion held the week-end of November 11-12 on the campus in connection with the homecoming football game between Ohio State University and the University of Pennsylvania.

On Friday afternoon, November 11, medical clinics were held and the alumni taken on a tour of inspection of the various medical buildings and the University Hospital.

That evening a dinner was held at the Faculty Club. Dr. J. H. J. Upham, dean of the College of Medicine, presided as toastmaster. Addresses were made by the Hon. George W. Rightmire, president of the University; Dr. C. A. Doan, head of the department of medical and surgical research, and Dr. Upham. Following the dinner, the alumni were entertained by the various medical fraternities which held "open house" for the occasion.

On Saturday morning, November 12, more clinics were held, followed by a pathological conference and a luncheon at the hospital at which J. L. Morrill, vice president of the University, was the principal speaker. A special section in the Stadium was reserved for the medical alumni for the football game in the afternoon.

Health Workers Hold Conference

Thirteenth Annual Conference of Ohio Health Commissioners with the State Department of Health was held November 16, 17 and 18 at the Deshler-Wallick Hotel, Columbus.

Numerous phases of public health work were discussed at the three-days meeting by speakers representing the medical and nursing professions, official public health departments and non-official agencies.

The organization of the Ohio Federation of Public Health Officials was completed at a dinner session held on November 17 and plans for the coming year formulated.

More detailed comments on the conference will be published in the January issue of *The Journal.*

Collection Schemes and "Rackets" Through Which Physicians Are Victimized ⁂ Some Suggestions as Safeguards

Judging by reports from members of the State Association in various sections of the state, collection agencies and finance companies of all descriptions have declared this winter an "open season" on members of the medical profession.

High-pressure sales campaigns which have been launched in Ohio by advance men for certain collection and finance agencies appear to be more than seasonal drives for new business.

Unsettled business conditions apparently have caused such firms to double their efforts to contact members of the medical profession, it being more or less general knowledge that physicians are experiencing difficulty in collecting their fees and have extended credit to many who ordinarily would be able to settle their bills promptly and in full.

Numerous inquiries have been received at the State Headquarters Office relative to some of the collection agencies and finance companies which are now soliciting business from physicians all over the state.

Repeatedly in the past, *The Journal* has commented on and analyzed various angles relative to the collection of fees and concerning dealings with collection agencies. Some of the more recent comments on this question were published in the July, 1932, November, 1931, September, 1931, November, 1930, October, 1930, July, 1930, March, 1930, and October, 1929 issues of *The Journal*.

However because of new angles which have arisen and because of the intensive campaign being made at present by various collection agencies and finance companies, a few general observations on the question are herewith presented for the sake of emphasis and as a renewed warning to members.

Collecting fees always has been one of the biggest bugaboos in medical practice. However, distasteful as the task may be to the average physician, it is one which must be performed if he is at all interested in keeping his practice out of the "red".

Owing to present economic conditions, it is extremely important that every physician be as business-like as possible in dealing with his clientele and use practical and effective means of converting his accounts into cash as promptly as possible.

SHOULD NOT AROUSE ILL-WILL

However, it should be remembered that collecting accounts is a process which requires diplomacy, skill, and a good knowledge of human nature. The physician should always keep in mind that his future practice depends to a large extent on the retention of friendly relations with his patients and their friends. Arousing of ill-will must be avoided. Moreover, the fact must not be lost sight of that circumstances differ in practically all cases. That is, the collection of fees cannot be accomplished by any uniform plan or universally adopted single method. Each physician must determine for himself what method, or methods, should prove the most practical and effective in individual cases.

Above all, physicians should not let themselves be stampeded into the use of doubtful and worthless collection schemes. Sending good money after bad is, mildly speaking, bad business. This is likely to happen unless the physician studies the question of collections seriously and decides to profit by the unpleasant experiences of some of his colleagues.

Every physician has three choices open to him in his business dealings with his patients.

First, he may neglect the business side of medical practice entirely; make no effort to minimize bad accounts, and exert no effort to collect accounts until the task is hopeless.

Second, he may follow an efficient office routine; establish a good system of bookkeeping and credit rating, and endeavor to collect his accounts himself by letter or personal solicitation.

Third, he may augment the second method by engaging a professional collector to go after accounts which have long resisted his own solicitation.

If he decides to make use of Method No. 3, the physician will let himself in for a lot of trouble, and possibly unanticipated expense, unless he is extremely wary. This is particularly true at the present time.

SOME ARE GOOD; MANY BAD

In considering the use of a straight out-and-out collection agency, or the sale of accounts to a finance company on a discount commission basis, the physician should bear in mind that there are two general types of collection and finance companies—good and bad. Moreover, he should remember that such agencies also may be classified as (1) nation-wide and (2) local.

In discussing collection agencies Dr. R. G. Leland, director of the Bureau of Medical Economics, American Medical Association, recently, made this pertinent observation:

"It is a good general rule to beware of the nation-wide type, but like all generalities this has some exceptions. Not all nation-wide agencies are 'gyps', but many 'gyps' are nation-wide. The crooked agency needs the whole nation in which

to work, because it cannot soon work the same territory a second time. Moreover, it usually employs high-pressure salesmen, who work fast and cover a lot of territory. Therefore, when approached by a salesman from such a nation-wide agency, the physician should investigate carefully before giving him any accounts.

Of course there are some nation-wide collection agencies which have built up a reputation for honest and efficient service. On the other hand, there are some local collection agencies whose reputation is not of the best.

However, it is probable that many unpleasant and costly experiences by physicians could have been avoided had they given first consideration to local firms and agencies in placing accounts for collection.

TRY LOCAL AGENCIES FIRST

Firms operated by persons with whom the physician is personally acquainted; whose reputation for honest and efficient service is well known; about whom information may be easily obtained, and whose methods of operation may be checked frequently, are, in the long run, the safest to deal with, and in the best position to provide service comparable to the commissions charged.

However, occasionally a physician is located where there is no local collection agency. This forces him to continue trying to make collections himself or to engage some state-wide or nation-wide agency to assist him. When confronted with this situation, the physician must act cautiously.

Before he definitely engages an agency—and this applies to local agencies, as well as nation-wide—to collect his accounts, the physician should make a detailed investigation, or have some competent person to do so for him, of the history and reputation of the agency; its personnel, its methods of operation, and the cost of the plan it offers.

In dealing with collection agencies and their representatives, the physician would do well to weigh carefully the following factors, all of which are based on actual experiences of physicians who have been victimized by unscrupulous collection agencies and other types of racketeers:

SOME POINTS TO REMEMBER

(1). High-pressure sales talk of a clever solicitor for a collection agency can in most instances be discounted. A salesman for a collection agency, especially one of questionable reputation, must be clever and a convincing talker. That's why he was hired and why he holds his job. He's not especially interested in whether the firm he represents can produce the service he claims it can. He's paid so much for every account he obtains for collection. He gets his fee first and regardless of the caliber of service rendered. After the deal is closed, he fades from the picture and lets the physician and the agency manager, usually miles apart, fight it out.

(2). The literature distributed by many collection agencies is unadulterated bunkum.

(3). References, endorsements, recommendations, credentials, etc., used by the solicitors may, or may not, be of any particular value. At least, they should not be seriously considered without verification. Solicitors of unscrupulous collection agencies have been known to use as reference the names of reputable and well-known individuals, firms and organizations without their knowledge or consent. It is not uncommon for the solicitor for a firm of bad reputation to use endorsements and credentials which were obtained under false pretense. In other words, the salesman for a crooked agency gambles on the belief that his prospect won't go to the trouble to verify the spurious references he presents. If he succeeds in signing up the physician, he uses his name at the next office he visits, and so on.

(4). A careful analysis should be made of the methods used by any agency. No physician should depend entirely on the word of the salesman or any other person connected with the firm. An effort should be made to get this information from persons who have used the service.

(5). No physician should be fooled by the high-sounding and imposing title of the agency. Some crooked agencies deceive their prospects by using a name similar to that of a dependable and honest agency. Changing the name of a firm is a comparatively easy matter. Some agencies change their names every year. Their reason is obvious.

(6). Extreme caution and judgment should be exercised when it comes to signing documents. Unless the physician understands thoroughly the content and meaning of all documents presented for his signature, he should refuse to sign them, and should continue to withhold his signature until they have been approved by a competent attorney.

NO CONTRACT IS NECESSARY

Mere mention of the word "contract" to some physicians is enough to recall to their minds unpleasant and costly experiences with collection agencies. The contract used by dishonest collection agencies is the trap used to catch the gullible client, and provides the means whereby the agency can "legally" swindle him.

The best authorities on collection methods and collection agencies have repeatedly warned that most of the best established and reliable collection firms never ask their clients to sign a contract and only use one in case the client requests it. All contracts are not traps, but many of them are, so the safest procedure for the physician to follow is to beware of all types of contracts, agreements, etc.

A few of the dangerous and costly features of

contracts used by dishonest collection agencies are as follows:

(1) A docket fee must be paid on each account turned over to the agency for collection regardless of whether any collections are made.

(2) The agency's commission is based on a percentage of the total amount of accounts turned over to it for collection, not on a percentage of the total amount collected. The agency may stop all activities after it has collected enough to cover its commission and return to the physician the accounts it has not attempted to collect but on which a commission has been paid.

(3) Placement of an account may be virtually an assignment, the account remaining in the possession and control of the agency indefinitely.

(4) Lack of a provision requiring the agency to make periodical reports on collections or to remit collections, if any, promptly to clients.

(5) Client is held liable for commissions on new business from debtors whose old accounts have been turned over to the agency for collection.

(6) By signing the contract, the client gives to the agency the power of attorney to handle his accounts as it wishes.

(7) Exorbitant charges for "special" services. The agency is given the sole right to decide what these "special" services shall consist of and when they shall be used.

(8) Charging a commission on uncollected accounts which the physician decides to withdraw from the agency.

(9) Charging of a larger fee for accounts collected in installments than for those collected in full. This encourages the collection of all accounts in installments.

(10) Provision that the agency may endorse checks and other instruments made payable to the client.

Although the foregoing list includes some of the more common methods used by dishonest collection agencies to defraud their clients, new tricks are constantly being devised by them to mulct the careless and gullible. In using professional services in the collection of accounts, physicians must put into actual practice the timely slogan, "Before investing, investigate".

Certain types of so-called financing companies are at present making a strong bid for the physicians' business. Some of these are out-and-out rackets. Several Ohio physicians have had costly and unpleasant experiences with several companies of this type during recent months.

SOME FINANCING RACKETS

These agencies are represented by clever advance men who make their plans sound so plausible and inexpensive that they succeed in getting the attention of the physician who is anxious to liquidate his mounting accounts. The solicitor is quick to explain that his company is not a collection agency but a financing company. It has nothing to "sell" but is in the market to "buy", it is explained, and to place a lot of money in the community. Emphasis is placed on the alleged altruistic motives of the company. It is pointed out that the company's idea is to help the physician get badly-needed cash and to assist his patients by offering them an easy way to meet their physicians' bills. Glowing endorsements are displayed and emphasis is placed on the "national" scope of the company's activities. Experience has shown that much of this is hokum.

The operations of one of these companies should be enough to warn physicians who have not already been tricked into doing business with agencies of this type. Its plan is briefly as follows:

The physician is requested to compile a list of overdue accounts and turn this list over to the company, the idea being for the company to investigate each account and interview each debtor relative to the financing plan. The company declares that it will get as many patients as possible to sign a judgment note for the amount which they owe the physician at 6 per cent interest. All accounts secured in this manner will then be purchased from the physician by the company on a discount basis, the size of the discount depending on the length of time the account has been running. At the time of purchase, the company will pay the physician cash on each account, subject to the discount agreement. The company will then take over the job of collecting each account in full, plus interest, to reimburse itself and get its commission.

The plan sounds simple, plausible and practical, and seems to involve little risk and small expense on the part of the physician.

However, it has proved exactly the opposite for several physicians who have tried it out, because of two "jokers" which are not obvious to the physician at the time of his transactions with the company's representative.

TWO "JOKERS" PROVE COSTLY

First, the physician has no control over the activities of the company during the time his accounts are in its hands for investigation and before they have actually been purchased by the company.

Second, the purchase agreement which the physician is asked to sign is full of tricks whereby the company can legally obtain from the physician considerably more than the commission it receives under the discount agreement.

One Ohio physician recently turned over to one such financing company a long list of accounts, ostensibly for investigation preliminary to the actual purchase of the accounts. At the same time he signed the company's "agreement" blank.

Before he had received any reports from the company relative to progress the company was making, in obtaining the signatures of patients to the judgment notes, the physician began receiving

reports from his patients that they had received letters from the company informing them their accounts with the physician had been taken over by the company and threatening them with litigation unless the accounts were paid immediately and directly to the company. The physician discovered that considerable ill-will had been aroused among his clientele by the letters.

Sensing the damage which might result should more of these letters be sent, the physician immediately asked the company to stop activities and return his list of accounts.

The company complied only after payment by the physician of a docket fee for each account which had been turned over, one of the provisions of the agreement which the physician had signed.

MORE BAD FEATURES CITED

Analysis of the purchase agreement indicates that the venture might have proved even more costly to the physician. In addition to authorizing payment of a docket fee on each account whether or not the company finally decided to purchase one or 100 accounts, the agreement contained the following bad features:

Granting of full authority to the company to settle, collect, adjust and act as attorney in fact for the physician in handling the accounts. This would give the company the power to take court action and perform all manner of "special" services, at considerable cost to the physician;

Assignment of authority to the company to endorse for deposit and collection commercial paper received from all debtors;

Provision that payments made direct to the physician shall be turned over to the company;

No provision for periodic accountings by the company on collections or for information as to its activities;

Provision that in case the physician should withdraw an account or fail to furnish evidence of indebtedness of any account within 15 days after request, the account shall be considered as paid to the physician; meaning the physician would have to pay a docket fee on an account withdrawn or a protested account, and might have to pay a commission in case the company had performed any "special" services in handling that particular account.

PUT SOLICITOR ON "THE SPOT"

Not long ago, one authority who has devoted considerable time and study to the collection agency racket, suggested that the physician compile a list of questions and have this list conveniently at hand to spring on the collection agency representative when he calls. Some of the queries which he suggested might be used in the proposed list were:

1. Name and address of the company.
2. History of the company and date of organization.
3. Connection with other collection agencies, if any.
4. Experience of the company in collecting physicians' accounts.
5. Are collections by mail or personal contact?
6. Number of collectors employed and commission or salary of each.
7. If you use a contract, would you be willing to have it submitted to the physician's attorney?
8. Is the physician permitted to retain a copy of the contract?
9. Do you at specific intervals, remit in full for money collected? How often?
10. Do you make periodic reports on progress of collections?
11. Do you receive your commission before or after money is collected?
12. Do you charge a fee for accounts withdrawn by the physician?
13. Do you notify the physician whenever legal action is contemplated or "special" services are needed?
14. Are your records in connection with his accounts open to inspection by the physician?
15. Submit copies of your collection letters and sales literature.
16. Present a list of banking references, schedule of fees, and names and addresses of some of your satisfied clients.

Even these precautions may not provide the physician with sufficient safeguards against the agency which is experienced in disreputable practices. In the final analysis, the safest course for the physician to follow is to make use of local firms and services whose reputation is well known or about which information may be readily obtained; or to continue to make his own collections, remembering if certain sound business precautions are taken when accounts are opened that the number of accounts which later prove bad and uncollectable will be smaller, the financial results better, and the relations between physician and patients less likely to be disturbed.

Professor Howard Dead

Alumni of the old Starling Medical College will regret to learn of the death of Professor Curtis C. Howard, aged 78, for nearly 40 years professor of toxicology at that institution, at Grant Hospital, Columbus, on October 23. Professor Howard was a member of the first graduating class at Ohio State University. He was an honorary member of the Columbus Academy of Medicine. Surviving are two sons and two daughters.

Announcement has been made that the American College of Physicians will hold its 17th annual clinical session in Montreal, February 6 to 10, 1933. Headquarters will be at the Windsor Hotel.

At a recent meeting of the Board of Directors of the American Society for the Control of Cancer, it was voted to make the *Bulletin* of the society its official organ and to discontinue the present relationship between the society and the *American Journal of Cancer*.

How to Avoid and Prevent Suits for Alleged Malpractice and Some of the More Common Causes of Such Litigation Discussed by Chairman of the Committee on Medical Defense

By J. E. Tuckerman, M.D., Cleveland, Ohio
Chairman, Committee on Medical Defense, Ohio State Medical Association

'How to avoid lawsuits"—now that surely is some subject. It covers a lot of territory and the truth is there is nothing to prevent anyone from suing anyone for anything if so minded to do. There is no sure preventive. But from some fifteen or sixteen years of observation, I do know that most suits filed against physicians incident to their professional work are unjust. Most such suits never should have been started and I am also certain that many of them would not have been but for some inadvertence or thoughtlessness on the part of someone, either some physician or those associated with him in his office or work.

The accompanying article by Dr. J. E. Tuckerman, Cleveland, chairman of the Committee on Medical Defense, of the State Association, is one of a series being published in *The Journal* on business and legal questions of particular interest and importance to members of the medical profession and their secretaries. The papers reproduced in part in the series comprised a course in business administration presented by the Academy of Medicine of Cleveland in conjunction with the Cleveland Retail Credit Men's Company and are being published with their consent and through their courtesy. The discussion presented by Dr. Tuckerman should be of special interest to the membership inasmuch as it deals with a subject of unusual importance to every practicing physician.—*The Committee on Publication.*

These things do not happen out of a clear sky. There is always some starting point to them and usually it is because someone has made some remarks that were not warranted.

Now I am sure all of us are loyal to our immediate associates and are eager to aid them to success but we must always remember that success is never achieved by belittling the work of others in the same line. It is so easy to criticize somebody else and it is so easy to be led into criticism without thinking. And so remember that success is never built upon belittling the work of others.

One of the serious faults is the habit of making remarks about someone else or about the results that they get, without thinking that perhaps you do not know all the facts concerned.

It is always well to remember that that patient who comes into a physician's office very possibly was in some other physician's office before. And what is more important for you to remember is that that patient very probably will go to some other physician's office afterwards. So it is well to guard your tongue.

It is unwise to give snapshot opinions upon hypothetical questions. Most of them are loaded. Not only that, it is unfair by acquiesence to imply criticism of somebody else.

Now theoretically, I suppose that any professional man might be sued for mal-practice; yet the only profession so afflicted is that of the physician or the dentist.

I do not recall ever hearing of such a suit being brought against an architect. Did you ever hear of an attorney being sued for mal-practice? Not often. Where is the attorney who would like to bring such an action against another attorney? Yet there are those who profess surprise that physicians are reluctant to testify against one another.

PUBLIC MISUNDERSTANDS

The physician deals with the human body. He is the one repairman from whom the public seems to expect a perfect result, under all circumstances. And when it is a mal-practice suit the man on the receiving end is usually a physician.

There are some general principles that are not well understood by the public. Contrary to popular notion, a license to practice medicine does not confer a privilege. It imposes certain obligations.

The license to practice medicine is issued under the police power of the state and it is not for the purpose of conferring anything upon the physician. It is for the purpose of protecting the public. A license—and I say it advisedly—is a liability and not an asset. If the physician would avoid trouble with the state he must under penalty of fine report births, deaths, wounds from suspicious causes such as gun or stab, communicable diseases. And right here may I pause to remark that very frequently you report communicable diseases over the protest of your families. And yet, if you do not, you are liable to a fine of $50.00 for neglecting that little formality.

The physician, you know, is expected to give free professional services to the poor in hospitals and elsewhere. Contrary to current belief in many quarters, the physicians giving this service receive no pay for attending free cases in hospitals or clinics. Many people who go to clinics and hos-

pitals imagine the physician receives pay for taking care of them.

HALF OF PLAINTIFFS INDIGENTS

And yet, fully fifty per cent of the mal-practice suits against physicians are brought on behalf of indigent persons. So the physician when he accepts a charity patient or a charity position merely increases his possibility of being sued.

In general, physicians who observe the amenities avoid much unpleasantness.

The rules of ethics or the code of ethics are designed to protect the patient and not for the convenience of the physician.

Remember, if a patient presents himself at the doctor's office, he indicates by so doing that he is free to come to that doctor and that doctor is really under no obligation to inquire whether he has been elsewhere. If however you are called to a home where it is quite obvious that the individual has been sick for some time, one of the things you should know is whether they have a physician and whether that physician is still in charge. This is not to protect the physician in any property right in that patient; but to assure the patient proper care. The patient has a perfect right to discharge you and hire anybody else he wants at any time. In fact, it is sometimes wise if you find the patient dissatisfied, to fire yourself before the patient fires you.

Always remember that the first physician should have been released before the second physician steps in. If you will follow the ordinary dictates of doing to others as you would like done to yourself, you'll never get into trouble on this score.

The man dealing with mental cases must remember that even the insane cannot be restrained of liberty—at least, in Ohio—against his will without inquest and commitment through the Probate Court. One of our physicians here was sued and the thing had to go through the lower court and the Court of Appeals because he merely assisted a husband in taking his wife, who was mentally deranged, in a cab to a sanitarium without proceeding through the Probate Court.

It is never wise to give an anaesthetic unless a third person is present. The figment of the dream state sometimes, particularly in neurotics, may create in the patient beliefs contrary to fact which may prove very embarrassing. It is always advisable to have a third party within hearing when making physical examinations of women.

PRIVILEGED COMMUNICATIONS

You hear a great deal about privileged communications. Remember that privileged communication is a privilege which rests in the patient and not in the doctor. The whole idea of the privileged communication is for the protection of the patient and not for the convenience of the physician.

There is a saying which says, "Speak no evil of the dead". I would add to that and say, "And reveal nothing to a third party except in the presence of or on the written request of the party involved". But an inquiry by telephone? Well, if your reply is to be a clean bill of health you can risk it, otherwise not.

Many of you may do work for factories. It is unwise to make a report to a third person in a factory unless you know that person is authorized to receive that report.

Recently a suit originated because a certain report was made by a physician to a nurse in a factory. The man lost his employment on account of the report. He sued for libel and obtained judgment.

Reports to the Industrial Commission are perfectly all right insofar as the physician is concerned but the physician should never give out such report to parties other than the Industrial Commission, although it is true the Industrial Commission reports are open property to the public.

It is assumed that when a man presents himself to the factory physician at the factory for examination he thereby consents to having what facts are found divulged to the proper individuals in the factory. The same is true in regard to examinations by insurance company physicians.

If you go to the home for the purpose of making an examination on behalf of an insurance company or others, be very certain to make it clear to that person who you are, why you have come and who you represent. If then he submits to an examination, he waives his right for you to use that information for the parties you represent.

As to the general subject of mal-practice: Let it be clearly understood that a physician is not required by law to respond to a call or to assume the care of any individual. Common humanity dictates that he render aid in an emergency. What this entails may be very much more in a rural community than in the city where hospitals and police ambulances are handy.

However, whenever a physician does undertake to care for a patient, he assumes a very definite contract to use the care, the knowledge and ability average in his community at the time and where he practices.

This does not mean the physician guarantees a cure. It is the privilege of the quack and charlatan to guarantee a cure and not of the physician.

EASY MONEY RACKETS

Many claims of mal-practice are most absurd. One recently was made by a healthy mother, with a living child, who felt that she should have been delivered by Ceaserian section because her labor was somewhat protracted.

Many suits are just nuisance suits. They are filed or started or threatened in the hope of a settlement in a nominal sum in the desire to get easy

money. The most prolific source of suits so far as physicians are concerned are fractures; next, burns either due to *X*-ray lamps or hot water bottles; third, failure to have someone in charge when absent in case you have agreed to take care of an obstetric case. It is very important not to overlook that fact that if you have been engaged to take care of an obstetric patient, it is your business, if you are away so that you cannot be reached, to provide that that patient's needs will be covered. And, of course, we occasionally have suits because sponges or other things have been left within the abdomen.

Unfortunately, mending broken bones is not as simple as mending broken chairs. With the chair you first decide whether it is worth mending—with the patient you have no such choice.

All you can do, is do your best and so guard your actions as to be able to defend them in the event the patient does not get what he considers a good result. Bad results do not by any means constitute evidence of carelessness or neglect constituting mal-practice.

X-RAY PICTURES ESSENTIAL

Never judge others' results without knowing all the facts. Always protect yourself in fracture cases or in injuries where fractures may be present by having an *X*-ray record.

Always have a picture "before and afterward". Then use the recognized methods, and in conditions doubtful as to outcome it is well to have consultations. Curiously enough, there are a great many fractures that do not actually need an *X*-ray examination but the attitude of the public and the attitude of the courts, or I should say, of jurors, is such that if you should have neglected to have an examination made, it is very unfortunate in event of suit. Of course there are many cases in which it is absolutely necessary to have such a picture for good results.

You should always keep records of your visits, the treatments, the instructions, and it is always well to refuse to continue with a patient who will not take your advice and follow it; particularly in fracture cases. But, remember you should never dismiss a patient from your care without due notice and giving him time to employ another.

Suppose a minor comes to the office for instance with a fracture—sometimes school children do—you put the hand up on a splint and send the child home and tell him to come back at such and such a time. It is not sufficient that you have told the child to come back unless the parent or a guardian was with that youngster. If that child does not come back at the time appointed, it is up to you to know why and to find out.

No instructions given to a minor will protect you in case of law-suit. The instructions must be to the responsible person: to parent or guardian. Not only that, but the child can sue you any time up to a year after becoming of age.

SAFETY FIRST ADVICE

One of the very important things that should be known and heeded by any person before using the *X*-ray for an examination, and especially for treatment, is whether that person has had *X*-ray examinations or treatment or other light therapy recently. Not only that, but the individual in the office must take great care that there be no shocks from the electrical overhead wiring. It isn't sufficient that you tell the patient to be careful and stand away. It is essential that when you make an exposure you know the patient is where he will not be touching wires.

Suits for accidental death and for other injuries are not at all uncommon. The physician who employs a technician to make such examinations must be pretty certain that that individual has been well trained because the physician will be held liable for the action of the technician while under his directions or while in his employ. There have been some suits where it was necessary to settle because it was shown that the technician was an unreliable and illy trained person.

Therapeutic Lamps: Ordinarily you would think the only thing that could happen there would be to get scorched by them. Of course that must be watched. But we have on record an instance where a suit was filed because a celluloid comb caught fire. It is not enough to tell the patient to take celluloid combs out of the hair. You must know that there is no such comb left in the hair if there is any possibility of the heat of a lamp setting it afire.

I was not going to touch on sponges, but for the benefit of the surgeons here present, I might state that sponge counts in your hospital are no longer a protection. You cannot rely on that, it is up to the surgeon to know that the sponge isn't in the belly.

STATUTE OF LIMITATIONS

You have been advised to send bills promptly; to follow up your collections, but I wish you would remember that in a profession so subject to the possibility of mal-practice claims you must think twice before starting suit to collect.

It is well to remember that a suit for damages in the State of Ohio is outlawed after one year from the date of service; therefore, if you start suit to collect inside of a year's time you may get a suit for damages in response. But if you wait until the year is up, the worst that can happen is they will allege mal-practice in order to get out of paying your bill.

I know that does not set very well. We feel we should receive our fees when they are due us. But when you have patients who are not exactly satisfied, it is just as well to "let sleeping lions lie". Don't stir them up. That doesn't say don't try to collect, but don't sue for collection. You know one counter-suit will cost you a whole lot

more than the loss of some of those bills and make you a lot more annoyance.

There is another little trick you want to watch. If a disgruntled patient comes back to you, make perfectly certain that he is not trying to re-establish your status as physician in his particular trouble.

There is not much else that I can add except that all operation records should show persons present, whether in the hospital or office or the home; should give the pertinent details. And, as I have said before, daily records of the calls, what was done, and the instructions. Because no matter what you may think, in case a suit is filed the only thing that the attorney can argue your defense upon is the evidence which he can present and if you do not have the records, how can he present the evidence?

I think I have indicated that gossipy comment, belittling of others, complacent listening to complaints about other physicians, is poor policy. It never pays to run down somebody else. Sometimes those chickens come home to roost. After all precautions have been taken and the physician finds himself a target of a suit, there is only one safe rule and that is, "Don't Talk". See your attorney at once.

Census Figures Show More Appendicitis Cases in This Country

Although Census Bureau figures indicate that the annual death rate from appendicitis in the United States is higher than in other large civilized countries, it does not necessarily follow that there are more deaths per capita in this country than in other nations, according to a statement issued recently by the United States Public Health Service.

Appendicitis caused 17,687 deaths in the Registration Area of the United States in 1929, it was explained, but this forms no basis to believe that Americans are peculiarly liable to death from this ailment. This number may be no higher in proportion to total population than in other large countries, where death rate figures are lower, it was pointed out in the statement, which also contained the following information:

Appendicitis might be called an "American" disease. Until comparatively recently, it was not recognized in England and other countries advanced in medical science. American physicians and surgeons have been the instigators of research and study of appendicitis. They are responsible for most of the progress that has been made in recognizing causes, effects, and cures of the disease.

The operation for removal of appendix, once considered rather serious, is now looked upon as very ordinary. Because of nation-wide research in this country, American physicians are becoming more and more efficient in diagnosing the disease. As a result, there are more operations for appendicitis, with a corresponding increase in death rate, in the United States.

Many instances of apparent stomach and intestinal disorder which at one time in America, and now in many other countries, might have been incorrectly diagnosed as any one of a variety of diseases, are now correctly attributed to appendicitis. In compiling figures for death rates, then, it is logical to assume that in countries where appendicitis has not been studied with the intensity with which it has in the United States, many deaths in reality caused by appendicitis are attributed to some other disease.

If this is true, and there is every reason to believe that it is, there is less ground for the assumption that Americans are highly susceptible to appendicitis, or that cases of the disease in this country exceed those in any other.

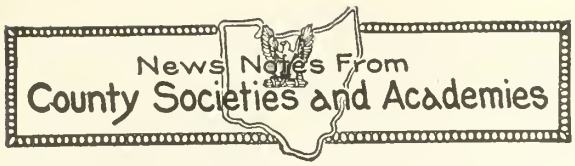
It has been suggested that our high death rate from appendicitis may be due to inadequate hospital facilities. Rather, a more logical belief is that the rate appears high because we have more adequate facilities than other nations, and because we are more competent in correctly diagnosing the disease.

According to Census Bureau figures, the disease has increased in relative frequency from 13.4 per 100,000 in 1920 to 15.2 in 1929. Figures for approximately 60 large cities show an increase since 1919 from 13.3 to 18.1 deaths per 100,000.

Although it appears that this increase may be due to an increased number of cases, or possibly to inadequate facilities for taking care of the normal number of cases, a more practical assumption is that medical science has progressed sufficiently in this country during the last 10 years to recognize deaths caused by appendicitis, and to distinguish them from deaths from other stomach or intestinal disorders.

There is nothing in American climate, diet, or condition of general public health to indicate that residents of this country are any more susceptible than the residents of any other country. Canada, with somewhat similar conditions, has a lower death rate, according to figures in a recent report. This report attributes far lower death rates to many other countries when compared to that of the United States.

One important phase to consider is that America has far more doctors, who are making far more diagnoses, than any other nation. There are over 143,000 medical men engaged in practice in the United States. This total represents one, on an average, to every 726 inhabitants, which is nearly twice the ratio in any other country, and more than double the ratio in England. It is natural that in their practice, American doctors come across more appendicitis cases than doctors of other countries. Also, because of their wider experience with the disease, they may recognize it more easily than foreign doctors.



First District

ACADEMY OF MEDICINE OF CINCINNATI
(George B. Topmoeller, M.D., Secretary)

November 7—General session. Program: "Further Report of the Public Relations Committee", Dr. R. S. Austin; "The Undernourished and Tuberculous Child", Dr. Albert J. Bell; discussion by Dr. H. Kennon Dunham and Dr. John Hunt.

November 14—General session. Program: "The Newer Outlook Upon Chronic Arthritis", Dr. Ralph Pemberton, Philadelphia.

November 21—General session. Program: "Prostatic Resection", Dr. Henry B. Freiberg; discussion by Dr. E. O. Smith and Dr. E. O. Swartz; "Some Remarks on Medical Education", Dr. David A. Tucker; discussion by Dr. J. C. Oliver and Dr. A. C. Bachmeyer.

November 28—General session. Program: "A Method of Studying Bright's Disease", Dr. Jean Oliver, Long Island College of Medicine, N. Y.

Clermont County Medical Society held its annual turkey dinner at the Grant Memorial Building, Bethel, on November 16. Following the business session, the society was addressed by Dr. John A. Caldwell, Cincinnati, Councilor of the First District, on organization matters, and three other Cincinnati physicians, Dr. Charles T. Souther, Dr. Clifford J. Straehley, and Dr. Francis X. Siegel.—Bulletin.

Fayette County Medical Society at its regular meeting on November 3 at Washington C. H., was addressed by Dr. Glen Nisley, Chillicothe. Dr. Nisley discussed chronic diseases, the subject of his paper being "The Other 20 Per Cent", meaning the 20 per cent of syphilitics who do not give a positive Wassermann.—James F. Wilson, M.D., Secretary.

Warren County Medical Society met in regular session November 1 at Harmon Hall, Lebanon. The guest speaker was Dr. Mark Millikin, Hamilton.—News Clipping.

Second District

Clark County Medical Society held its regular semi-monthly luncheon meeting on October 12 and October 26. The first meeting, held at the Bancroft Hotel, was addressed by Dr. Warren C. Breidenbach of the Stillwater Sanatorium, Dayton, on the subject, "Medical Tuberculosis". The second meeting was held at the new City Hospital. Following the luncheon, a roundtable conference was held.—News Clipping.

Darke County Medical Society was addressed at its regular meeting on October 14 by Dr. Vernon Hart, Dayton, formerly head of the orthopedic department at the University of Michigan School of Medicine. Dr. Hart discussed "Diagnosis and Treatment of Infantile Paralysis".—News Clipping.

Greene County Medical Society met in regular session in Xenia on November 3. Dr. H. W. Burnett, Dayton, was the guest speaker, discussing "*X*-ray Therapy". Many of the newer advances in *X*-ray therapy were described. Following the meeting, luncheon was served.—H. C. Schick, M.D., Secretary.

Miami County Medical Society at its meeting on November 2 at the Stouder Memorial Hospital, Troy, was addressed by Dr. A. F. Kuhl, Dayton, on "Pneumonia". Dinner was served after the program.—Bulletin.

Montgomery County Medical Society was addresesd by Dr. Gordon Erbaugh and Dr. E. M. Smith at its regular meeting October 21 at the Fidelity Medical Building. Dr. Erbaugh presented a paper, "Review of the Present Literature on Eclampsia". The subject of Dr. Smith's talk was "Pernicious Anemia". The first paper was discussed by Drs. Dooley and Gilfillen; the second by Drs. Simpson and Cassel.

At the November 4 meeting of the society, two papers were read, one by Dr. H. F. Koppe on "Dysthyroidism Following Pregnancy and Associated with the Menopause", the second by Dr. A. D. Cook on "Endocrine Disturbance in Toxemias of Pregnancy". Dr. Koppe's paper was discussed by Drs. Olch and Wagner; Dr. Cook's by Drs. Clarke Sullivan and J. K. Hoerner.

Dr. Samuel A. Levine, Boston, was the guest speaker at the November 29 meeting of the society at the Miami Valley Hospital. A complimentary dinner was given by the hospital. Dr. Levine discussed "Heart Disease".—Bulletin.

Third District

Hancock County Medical Society held its regular meeting at the Elks' Club, Findlay, November 2. The principal speaker was Dr. Karl D. Figley, Toledo, who discussed "Some General Factors Concerning Sensitization". A general discussion followed the presentation.—H. O. Crosby, M.D., Secretary.

Hardin County Medical Society held a largely

attended meeting on October 20 at the Kenton Cafe. Dr. H. M. Platter, Columbus, president of the State Association, and Dr. J. P. Farson, Columbus, were the guest speakers. Dr. Platter discussed relationships between the county society and the State Association. Dr. Farson discussed various phases of the care and feeding of infants. Public health nurses of the county and a number of physicians from surrounding counties attended the meeting.—News Clipping.

Marion County Academy of Medicine opened its fall activities on October 11 with a well-attended meeting at the City Hospital. Dr. H. K. Mouser presented a paper on "Diseases of the Liver". A committee consisting of Drs. F. E. Mahla, Maud Bull and Robert Dombaugh, representing the Academy, and Dr. E. W. Imbody and Dr. F. R. Mann, representing the dental profession, was appointed to study the feasibility of establishing a physicians' and dentists' credit rating bureau. —News Clipping.

Mercer County Medical Society met October 20 at Celina with a large attendance. Dr. O. E. Harvey, superintendent of the Lima District Tuberculosis Hospital, was the principal speaker. He discussed "The Management of the Tuberculosis Hospital and the Care of Tubercular Patients". Dinner was served with Dr. D. H. Richardson and Dr. F. E. Ayers as hosts.—News Clipping.

Van Wert County Medical Society elected officers for the ensuing year at its regular meeting on November 1. The following were elected: President, Dr. A. T. Rank, Van Wert; vice president, Dr. W. J. Reuter, Ohio City; secretary-treasurer, Dr. R. H. Good, Van Wert; delegate to the state meeting, Dr. C. R. Keyser, Van Wert, and alternate delegate, Dr. C. A. Morgan, Van Wert. Dr. F. H. Hedges, Lima, was the guest speaker. His paper on "Value of Thorough Urological Diagnosis", was discussed by Dr. F. G. Maurer, Lima.—News Clipping.

Fourth District

ACADEMY OF MEDICINE OF TOLEDO AND LUCAS COUNTY

(A. P. Hanculf, M.D., Secretary)

November 4—General session. Program: "A Present Day Survey of the Prostate Gland with Moving Picture Discussion of the Modern Method of Transurethral Resection", Dr. H. W. Plaggemeyer, clinical professor of urological surgery, Detroit College of Medicine and Surgery, assisted by Dr. Carl G. Weltman, Detroit.

November 11—Section of Pathology, Experimental Medicine and Bacteriology. Program: "Newer Methods in the Study of the Anemias", Dr. Russell L. Haden, Cleveland.

November 18—Medical Section. Program: "Endocrine Growth Deficiencies", Dr. Robert L. Schaefer, Detroit.

November 25—Surgical Section. Program: Symposium on Obstetrics. Papers: "Caesarean Section—Indications and Technique", Dr. John Gardiner; "Operative Procedures from Below", Dr. R. C. King; "Episiotomy—Indications and Types", Dr. M. D. Haag.

The *Four County Medical Society* (Henry, Defiance, Williams and Fulton counties) held an interesting meeting October 20 at the Detwiler Memorial Hospital, Wauseon. Lectures were presented by Dr. Louis J. Hirschman, Detroit, and Dr. J. L. Reycraft, Cleveland. Discussions of the papers were led by Dr. Norris Gillette, Toledo, and Dr. W. W. Brand, Toledo.—News Clipping.

Ottawa County Medical Society met November 10 at Oak Harbor. The guest speaker was Dr. J. A. Muenzer, Toledo, who discussed "Some Recent Advances in Ovarian Therapy".—C. R. Wood, M.D., Secretary.

Wood County Medical Society held its regular meeting October 20 at the new Bowling Green General Hospital, recently established by Miss Clara Specht, R.N., and Miss Loretta Fahl, R.N., and which has been equipped to provide complete medical, surgical, obstetrical and *X*-ray service for the use of physicians of the county. The program was presented by Dr. W. W. Mannhardt, Custar, who read a paper on "Thirty Years Experience in the Practice of Obstetrics". The discussion was led by Drs. Boyle, Foltz, Whitacre and Rae.—R. N. Whitehead, M.D., Correspondent.

Fifth District

ACADEMY OF MEDICINE OF CLEVELAND

(Clarence P. Heyman, M.D., Secretary)

November 2—Pediatric Section. Program: "The Neurotic Child", Dr. C. F. Ulrich; "Soviet Care of Children (Stereopticon)", Dr. S. C. Lind.

November 4—Clinical and Pathological Section. Program: "Non-specific Interstitial Keratitis", Dr. H. V. Phelan; "Acute Appendicitis with Unusual Complications", Dr. W. Boukalik; "Acetone Treatment of Cervical Bleeding Due to Carcinoma", Dr. A. E. Bennett; "Cerebral Injury", Dr. E. F. Kieger; "Sympathectomy for Angina Pectoris Associated with Aortic Stenosis", Dr. Richard Dexter and Dr. James N. Wychgel; "Post Traumatic Cyst of the Kidney", Dr. H. L. Sanford; "Thrombocytopenic Purpura with Hemorrhagic Herpes Zoster", Dr. H. V. Paryzek; "Carcinoma of Bronchus", Dr. A. Szczytkowski and Dr. E. P. McNamee; "Polyserositis", Dr. W. S. Taylor.

November 11—Joint Meeting of Experimental Medicine Section and the Cleveland Section of the Society for Experimental Biology and Medicine.

Program: "Observations on Technique of Friedman Test for Pregnancy", Dr. Anna M. Young; "Morphology of Corpora Amylacea of Prostate", Dr. Robert A. Moore; "Coronary Arteries in Pneumatic Fever", Dr. H. T. Karsner and (by invitation) Dr. Francis Bayless; "Augmentation of Extracardiac Anastomoses of Coronary Arteries through Pericardial Adhesions", Dr. Alan Moritz, Dr. C. L. Hudson and Dr. E. S. Orgain; "Experimental Renal Ischemia (Preliminary)", Dr. Harry Goldblatt and (by invitation) Dr. James Lynch and R. F. Hanzel, Ph.D.; "Further Remarks on Creatinine Clearance", Dr. R. Dominguez and Elizabeth Pomerene, Ph.D., by invitation; "Host Adaptability of Treponema Pallidum", E. E. Ecker, Ph.D.

November 18 — General Session. Program: "The Pathology of Valvular Endocarditis", Dr. Howard T. Karsner; "Endocarditis", Dr. William S. Thayer, Baltimore, professor emeritus in medicine, Johns Hopkins University.

Ashtabula County Medical Society held its regular monthly meeting at the Hotel Ashtabula, Ashtabula, on November 8. Following dinner and a short business session, the society was addressed by Dr. Louis J. Karnosh, Cleveland, on "New Things in Neurology".—E. H. Merrell, M.D., Secretary.

Geauga County Medical Society elected officers for the coming year at its meeting on October 25. The following were elected: President, Dr. H. E. Shafer; vice president, Dr. Lura E. Gordon; secretary-treasurer, Dr. Isa Teed-Cramton; legislative committeeman, Dr. W. C. Cory; medical defense committeeman, Dr. C. F. Gilmore; delegate to state meeting, Dr. Lucy S. Hertzog; alternate, Dr. Cory. The society entered on its activities of the new year with a 100 per cent membership. Following the business session, Dr. M. H. Castle, Cleveland, presented a paper on "Infections of the Hand".—Isa Teed-Cramton, M.D., Secretary.

Lake County Medical Society and the Northeastern Ohio Dental Society held a joint meeting November 1 at the Parmly Hotel, Painesville. The principal speaker was Dr. I. L. Furnas, professor of prothetic dentistry, Western Reserve University, who presented an illustrated lecture on his explorations in Alaska where he studied the life of the Eskimo.—News Clipping.

Medina County Medical Society held its regular monthly meeting October 13 at the Evanon, Medina. Wives of the members were guests at the luncheon.—News Clipping.

Trumbull County Medical Society met in regular session October 20 at the Trumbull Country Club. The guest speakers were Dr. John D. Osmond and Dr. Clayton C. Perry, both of Cleveland. Each discussed "Diseases of the Large Intestines".—R. H. McCaughtry, M.D., Secretary.

Sixth District

Ashland County Medical Society held its regular meeting October 14, being addressed by Dr. Frank Harrah, Columbus. Dr. Harrah presented an illustrated lecture on "Urology", in which he explained the signs, symptoms and differential diagnosis of the various conditions found in the genito-urinary tract.—Paul E. Kellogg, M.D., Secretary.

Mahoning County Medical Society at its meeting on November 2 at the Youngstown Club was addressed by Dr. I. S. Ravdin, William White professor of surgical research, University of Pennsylvania Medical School. Dr. Ravdin spoke on "Water Metabolism in Clinical Patients". Arrangements were completed for the second annual public meeting to be held under the auspices of the society, on the evening of December 15 at Stambaugh Auditorium. The guest speaker will be Dr. Haven Emerson, professor of public health administration, College of Physicians and Surgeons. Columbia University. Dr. Emerson will speak on "Preventable Diseases and Their Control by Personal and Public Action". A year ago when the society presented Dr. Chevalier Jackson, Philadelphia, in a public lecture approximately 3,000 physicians and laymen attended the meeting and the society decided to make such gatherings an annual affair.—J. Rosenfeld, M.D., Correspondent.

Portage County Medical Society met November 3 at the home of Dr. L. W. Prichard, Ravenna. The program consisted of a case report on "Hereditary Chorea", by Dr. E. J. Widdecombe and a paper on "The Practical Artificial Feeding of Babies", by Dr. R. S. Friedley, Akron.—Bulletin.

Stark County Medical Society held its regular meeting November 1 at the Elks' Club, Canton. The guest speaker was Dr. E. C. Rosenow, Rochester, Minn., who discussed "Prophylactic Innoculation Against Colds, Sore Throats and Influenza". —Bulletin.

Summit County Medical Society met in regular session November 1 at the Mayflower Hotel, Akron. The principal speaker was Dr. T. B. Mallory, director of the pathology laboratory, Massachusetts General Hospital, Boston. Dr. Mallory discussed "The Pathology of Bronchial Asthma and Asthmatic Paroxysm".—Bulletin.

Seventh District

Columbiana County Medical Society held an interesting meeting November 10 at the Whist Club Rooms, Lisbon. The program consisted of motion pictures on four subjects, namely: Posterior Colporrhaphy, Orchidopexy with Hernioplasty and Varicocelectomy, Salpingo-Oophorectomy with Appendectomy, and Hernioplasty for Strangulated Ventral Hernia.—Bulletin.

Coshocton County Medical Society was addressed by Dr. J. W. Shaw at its regular meeting on November 3 at the Coshocton City Hospital.—News Clipping.

Tuscarawas County Medical Society had as its guest speaker at its meeting on October 13 at Dover, Dr. John O'Brien, Canton, who spoke on new trends in neurology.—News Clipping.

The November meeting of the society was held on November 10 at the Union Hospital, Dover. Dr. Carl R. Steinke and Dr. H. Vern Sharp, both of Akron, presented the scientific program. Dr. Steinke spoke on "The Newer Surgical Operations in General", and Dr. Sharp on "New Anesthetics".—Bulletin.

Eighth District

Fall meeting of the *Eighth District Medical Society*, composed of county medical societies in the Eighth Councilor District of which Dr. E. R. Brush, Zanesville, is Councilor, was held November 3 at the Lancaster Country Club. Following an excellent dinner, Dr. W. B. Taylor, president of the Fairfield County Medical Society, called the meeting to order and presented Dr. Brush as the permanent chairman. Following a brief business session, an interesting scientific program was presented by Dr. A. B. Brower, Dr. Vernon L. Hart and Dr. R. D. Arn of the staff of the Dayton Clinic. Dr. Brower spoke on "Anemia". Dr. Hart's paper was on "Fractures of the Elbow", and Dr. Arn's on "Surgery of the Sympathetic System". The discussion of the presentations was opened by Dr. W. A. Melick, Zanesville, and Dr. Robert Miller, Hemlock. Following the meeting, those present were taken on an inspection tour of the Lancaster Municipal Hospital. Arrangements for the successful meeting were made by Dr. Taylor, Dr. Carl Brown and Dr. Clark Axline of the Fairfield County Medical Society.

Fairfield County Medical Society met in regular session October 11 at Pleasantville. Dinner was served at the Methodist Church, after which Dr. Wells Teachnor, Sr., Columbus, addressed the society on "Cancer". News Clipping.

Guernsey County Medical Society was addressed by Dr. A. C. Ormond, Byesville, at its regular semi-monthly meeting October 20 at the Romance Restaurant, Cambridge. Dr. Ormond discussed "Spinal Anesthesia", presenting a report on 200 cases in which he had made use of it.—News Clipping.

Licking County Medical Society and the Licking County Dental Society held a joint meeting October 27 at the Warden Hotel. The principal speaker was Dr. John Dudley Dunham, Columbus, who spoke on "Inter-dependence of the Medical and Dental Profesisons". Discussions which followed were led by Dr. Homer C. Brown, Columbus, past president of the American Dental Association and chairman of the legislative committee of the American Dental Association, and Dr. E. A. Moore, Newark.—News Clipping.

Muskingum County Academy of Medicine held a dinner meeting November 2 at the Hotel Zane. The guest speakers were Dr. H. H. Dorr, chief medical examiner for the State Industrial Commission, and Dr. W. E. Elder, assistant chief medical examiner for the Commission, both of Columbus. Each spoke on the relationship between the medical profession and the Commission, and discussed the new rules and regulations recently promulgated by the Commission governing medical, hospital and nursing services in industrial accident cases. Many physicians from surrounding counties were in attendance.—News Clipping.

Ninth District

Scioto County—Regular meeting of the *Hempstead Academy of Medicine* was held November 14 at the Recreational Hall, Nurses' Home, with Dr. Wells Teachnor, Sr., Columbus, as the principal speaker. Dr. Teachnor discussed "The Facts About the Injection Method of Treating Internal Hemorrhoids". A buffet supper was served following the program.—Bulletin.

Tenth District

COLUMBUS ACADEMY OF MEDICINE

(John H. Mitchell, M.D., Secretary)

November 7—General session. Program: "Schuller-Christian Disease", Dr. Norman E. Lichty, department of pediatrics, University of Michigan.

November 13—Memorial service for the following deceased members at the First Congregational Church, conducted by Rev. M. H. Lichliter; David R. Alban, John W. Dawson, Isaac C. Edwards, Edgar M. Freese, William J. Gorey, Edgar M. Hatton, George A. Haveman, William Hoover, Curtis C. Howard, James M. Merryman, John E. Monger, Frank R. Morath, James M. Rector, Joseph A. Turner, George J. Walsh, Starling Wilcox and William J. Woodlin.

November 21—Clinical demonstration at Grant Hospital by members of the hospital staff. Program: "Laryngospasm", Dr. Herbert Emswiler; discussion by Drs. D. M. Johnson and E. H. Harris; "Hysterectomy", Dr. Robert B. Drury; discussion by Drs. I. B. Harris and W. B. Morrison; "Paralytic Ileus as a Complication in Obstetrics", Dr. S. J. Goodman; discussion by Drs. J. F. Baldwin and P. D. Scofield; "Myocardial Failure", Dr. E. F. McCampbell; discussion by Drs. R. A. Ramsey and E. E. Campbell.

November 28—General session. Program: "The Relationship of Hemoglobin in Pulmonary Tuberculosis", Dr. Donald Yochem.

Crawford County Medical Society met in regu-

lar session November 7 at the Elks' Grill, Bucyrus. Dr. W. W. Beauchamp, Lima, was the principal speaker. He discusesd "The Mental Factor in Disease or Medical Psychology". A buffet supper was served following the meeting.—Bulletin.

Madison County Medical Society was addressed by Dr. Hugh G. Beatty, Columbus, at its regular meeting October 26 at the London Country Club. The program was preceded by a luncheon.—News Clipping.

Ross County Medical Society at its meeting on November 3 at Chillicothe was addressed by Dr. G. Wayne Brehm, Columbus, on "Modern Prenatal Care".—News Clipping.

Union County Medical Society met at the Coffee Shop, Marysville, on November 8. Following a practical demonstration in dietetics by Dr. P. D. Longbrake, the program was devoted to consideration of public health and welfare problems arising during the present period of readjustment. Emphasis was placed on the injustice of relief programs in which physicians are neglected or are expected to reduce their fees while compensation for all other services and supplies is paid without question. The inadequacy of relief funds was stressed. It was pointed out that the failure of many local authorities to take advantage of relief legislation passed at a special session of the General Assembly is responsible for the problems now confronting many rural communities.—J. D. Boylan, M.D., Correspondent.

Deaths in Ohio

Daniel W. Baker, M.D., Youngstown; Cleveland University of Medicine and Surgery, 1890; aged 70; died October 29 following a six months' illness. Dr. Baker located in Youngstown in 1895. For the past 30 years he had been physician for the Mahoning County Jail.

Raymond Burton Bowen, M.D., Toledo; Toledo Medical College, 1913; aged 45; former member of the Ohio State Medical Association and the American Medical Association; died October 30 of heart disease. Dr. Bowen, a native of West Lodi, was a member of the staff at Mercy Hospital; physician at the Lucas County Jail, and a member of the Toledo Boxing Commission. Surviving are his widow, two sons, his father, Dr. A. D. Bowen, of West Lodi, three brothers and two sisters.

Charles W. Cable, M.D., Nelsonville; Medical College of Ohio, Cincinnati, 1880; aged 73; member of the Ohio State Medical Association and the American Medical Association; died October 14 of cancer. Dr. Cable had practiced in Athens County for the past 51 years. He was a member of the Presbyterian Church and affiliated with the Masonic and Knights of Pythias lodges. Surviving are his widow, one daughter, two brothers and one sister.

Osman C. Clary, M.D., Springfield; University of Louisville, School of Medicine, 1896; aged 57; died October 23 following an extended illness. Dr. Clary was born at Ironton. Before locating in Springfield six years ago, he had practiced at Waterloo, Gallipolis, Scottown and South Charleston. Dr. Clary was a member of the Masonic lodge. He is survvied by his widow, two sons, three daughters and one brother.

Albert W. Dumm, M.D., Columbus; Columbus Medical College, Columbus, 1876; aged 85; died November 12 of uremia; Dr. Dumm had practiced in Columbus for 44 years, locating there after practicing in Delaware for several years. He was a Spanish-American War veteran. Surviving are his widow, three daughters, one sister and two brothers.

Francis C. Gray, M.D., Dayton; Starling Medical College, Columbus, 1878; aged 74; member of the Ohio State Medical Association and the American Medical Association; died October 22. Dr. Gray, son of the late Dr. William Bell Gray, was born at Monticello, Indiana. After leaving medical school, Dr. Gray joined his father in the practice of medicine at Lewistown. In 1890 he moved to Dayton. Dr. Gray was for many years senior surgeon at St. Elizabeth's Hospital, retiring three years ago. He was a member of the Masonic and Pythian lodges, and the Methodist Episcopal church. Surviving are his widow and one daughter.

Alvah W. Grosvenor, M.D., Sidney; Medical College of Ohio, Cincinnati, 1882; aged 76; member of the Ohio State Medical Association and the American Medical Association; died October 25. Dr. Grosvenor began the practice of medicine at Lockington. Later he moved to Hardin and in 1894 to Piqua. In 1905, he located in Sidney where he practiced until last April when he retired because of his health. He was a member of the Presbyterian Church and the Masonic Lodge.

At the time of his death he was treasurer of the Shelby County Medical Society. Dr. Grosvenor is survived by his widow, three sons, one daughter and two sisters.

James J. Hathaway, M.D., Carrollton; Western Reserve University, School of Medicine, 1902; aged 61; died October 4 of heart trouble. Dr. Hathaway was a native of Medina County. He practiced for one year in Cleveland before locating in Carrollton in 1904. Dr. Hathaway served five years as county coroner and was the first health commissioner of Carroll County. He was a past president of the Rotary Club; a director of the Carrollton Savings and Loan Company, and a member of the Presbyterian Church and the Masonic Lodge. During the World War he held a first lieutenancy in the Medical Corps. He is survived by his widow, one son and one daughter.

John T. Haynes, M.D., Sandusky; Miami Medical College, Cincinnati, 1889; aged 68; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died November 3 following a stroke of paralysis. Dr. Haynes has been chief surgeon at the Ohio Soldiers' and Sailors' Home at Sandusky since 1891. He was a native of Butler County and received an appointment as assistant surgeon at the home in 1889 the same year he graduated from medical school.

Henry Justus Herrick, M.D., Hudson; Western Reserve University, School of Medicine, 1894; aged 65; former member of the Ohio State Medical Association and the American Medical Association; died October 30 following an extended illness. Dr. Herrick was born in Cleveland, the son of the late Dr. H. J. Herrick. He practiced in Cleveland until 1907 when he moved to Hudson. During the World War, Dr. Herrick was a captain in the Medical Corps. He was a former president of the Hudson Club; a member of the Hudson Library and Historical Society; the Episcopal Church, Board of Public Affairs, Masonic Lodge, Delta Tau Delta Fraternity, Cleveland Athletic Club, and was a former health officer and councilman of Hudson. Surviving are his widow, one daughter, and two brothers, one of whom is Dr. Frederick C. Herrick, Cleveland.

George W. Huffman, M.D., Defiance; Jefferson Medical College, Philadelphia, 1894; aged 71; former member of the Ohio State Medical Association and the American Medical Association; died October 31 of cerebral hemorrhage. Dr. Huffman began practice at Port Clinton and in 1897 moved to Defiance where he practiced until 1929 when his health failed. He belonged to the Masonic lodge. His widow survives.

John N. Lenker, M.D., Cleveland; College of Physicians and Surgeons, Baltimore, 1886; aged 67; member of the Oiho State Medical Association and a Fellow of the American Medical Association; died October 20. Dr. Lenker had practiced in Cleveland since 1898. Until three years ago he was head of the otolaryngology departments at Cleveland City and St. Luke's hospitals. Surviving are his widow and one sister.

John Warren Means, M.D., Troy; Pulte Medical College, Cincinnati, 1880; aged 76; died October 15 following a stroke of apoplexy. Dr. Means had practiced at Troy for the past 50 years. He was active in political and civic circles, having been a member of the city council, a member of the board of education and county coroner. Dr. Means belonged to the Pythian and Odd Fellows lodges, the Rotary Club and the Methodist Church. Surviving are one daughter, one sister and one brother. Two brothers, Dr. W. J. and Dr. Charles S. Means, both of Columbus, preceded him in death.

John Emerson Monger, M.D., Columbus; Medical College of Ohio, Cincinnati, 1902; aged 55; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died October 28 of cerebral hemorrhage following an extended illness. Following graduation from medical school, Dr. Monger located in Greenville where he practiced medicine until 1917 when he was named state registrar of vital statistics. In 1923, Dr. Monger was appointed by Governor Donahey as state director of health, a post he held for six years. At the time of his death, he was managing director and vice president of the U. S. Standard Products Company, Chicago. Dr. Monger was nationally prominent in public health work during and following his term as state director of health. Shortly before his death, Dr. Monger was honored with an honorary fellowship in the American Public Health Association. He was a veteran of the Spanish-American War and a member of the Elks' Lodge. Surviving are his widow, two sons and one daughter. Many prominent health officials from other states attended the funeral services.

William J. Ogier, M.D., Wellston; Medical College of Ohio, Cincinnati, 1905; aged 53; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died October 19 of coronary thrombosis. Dr. Ogier was a native of Hamden and located in Wellston soon after leaving medical school. He was a past president of the Jackson County Medical Society, trustee of the Presbyterian Church, member of the Masonic Lodge and a past president of the Rotary Club. Surviving are his widow and two brothers.

J. Milton O'Neal, M.D., Zanesville; Starling Medical College, Columbus, 1892; aged 66; member of the Ohio State Medical Association and the American Medical Association; died November 11. Dr. O'Neal was a life-long resident of Muskingum

County, having practiced at Norwich and New Concord previous to moving to Zanesville. He was health commissioner of the county for eight years, retiring several years ago. Dr. O'Neal was a member of the Masonic Lodge and the Norwich Grange. Surviving are one son and two sisters.

Craven W. Osborn, M.D., Dayton; Miami Medical College, Cincinnati, 1903; aged 65; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died October 19 of a fractured skull received in an automobile accident. Dr. Osborn has served as a district physician under the Dayton city government and was in charge of the city baby clinic. He was a native of Adams County, locating in Dayton about 20 years ago. Surviving are his widow, one son and one daughter.

David E. Quinn, M.D., Dennison; George Washington University Medical School, Washington, D. C., 1895; aged 63; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died October 19 of heart disease. Dr. Quinn was a native of Tuscarawas County and was at one time employed as physician by the Pennsylvania Railroad. He was a member of the Methodist Church. Surviving are his widow, his mother, and five sons, one of whom is Dr. David Quinn, Otten, N. Y.

William W. Reynolds, M.D., Proctorville; Rush Medical College, 1883, and Jefferson Medical College, 1892; aged 77; died October 25 at the home of his son, Dr. Charles O. Reynolds, Huntington, West Virginia. Dr. Reynolds opened an office in Proctorville soon after his graduation from medical school. Later he accepted a teaching position at the Ohio Medical College, Columbus, being the first to occupy the chair of anatomy at that institution. For the past 35 or 40 years he had practiced in Proctorville. He was a member of the Masonic Lodge and the Methodist Episcopal Church. Surviving are his widow, one son, one daughter, two sisters, and one brother.

Samuel Riegelhaupt, M.D., Cleveland; University of Vienna, 1886; aged 70; member of the Ohio State Medical Association and the American Medical Association; died August 24. He had practiced in Cleveland for the past 40 years. He is survived by two brothers.

Robert K. Smith, M.D., Logan; University of Cincinnati, College of Medicine, 1928; aged 30; died October 17 of acute nephritis. Dr. Smith practiced at Wewoka, Oklahoma, after graduating from medical school, returning to Logan in 1930 to join his father, Dr. A. K. Smith, in private practice. He was affiliated with Kappa Sigma fraternity, Nu Sigma Nu medical fraternity, the Masonic Lodge and Presbyterian Church. Besides his parents, he leaves one sister.

Israel H. Stevens, M.D., Cuyahoga Falls; Starling Medical College, Columbus, 1891; aged 64; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died October 23 after a brief illness. Dr. Stevens had practiced in Cuyahoga Falls for the past 16 years, moving there from Youngstown. He also had practiced at Aurora and Ravenna. He was a member of the Masonic Lodge and Congregational Church. His widow survives.

Frank H. Suchy, M.D., Cleveland; Western Reserve University School of Medicine, 1900; aged 54; member of the Ohio State Medical Association and the American Medical Association; died October 8 of peritonitis following an operation for ruptured gall bladder. He is survived by his widow, two daughters, his mother and one sister.

Philip F. Weamer, M.D., Coldwater; Cleveland College of Physicians and Surgeons, 1893; aged 66; member of the Ohio State Medical Association and the American Medical Association; died October 14 of heart trouble. Dr. Weamer was active in civic enterprises of Coldwater as well as in politics. He was serving his third term as mayor of the village at the time of his death. Surviving are his widow, three daughters, one son, Dr. Gillum Weamer, Chicago, and one brother.

KNOWN IN OHIO

John Abell, M.D., New York City; University of Michigan, School of Medicine, 1929; aged 27; died October 19 from injuries received in an automobile accident. Dr. Abell, the son of Dr. and Mrs. Charles E. Abell, Canton, was in New York City taking post-graduate work at the time of his death. He had practiced at Cincinnati and Yankton, South Dakota. Surviving are his parents and one sister.

Walter B. Denslow, M.D., Pittsburgh, University of Pennsylvania, School of Medicine, 1895; aged 60; Fellow of the American Medical Association; died October 25 of pneumonia. Dr. Denslow was born and reared in Wellsville. He leaves his widow, one son and two brothers.

Benjamin F. Hoy, M.D., Syracuse, Indiana; Toledo Medical College, Toledo, 1883; aged 71; member of the American Medical Association; died October 9 of paralysis. Dr. Hoy was a native of Holmes County and attended Muskingum College before entering medical school. He practiced at Apple Creek before moving to Indiana. Surviving are his widow, one son, one daughter and two sisters.

William C. Jones, M.D., Chicago; Eclectic Medical College, Cincinnati, 1909; aged 48; member of the American Medical Association; died October 30 of self-administered poison. Dr. Jones was the son of the late Dr. B. K. Jones of Kenton. For several years he practiced in Kenton in partnership with his father. For the past 20 years he

had been a resident of Chicago. He leaves his widow, one son, his mother, two sisters and one brother.

Edgar Knoop, M.D., San Diego, California; Miami Medical College, Cincinnati, 1902; aged 60; former member of the Ohio State Medical Association; died October 12 of heart disease. Dr. Knoop was a native of Troy and practiced in Cincinnati for several years until 1929 when he moved to California. He is survived by his widow and one son.

Owen B. Van Epp, M.D., Cashiers, North Carolina; Cleveland Pulte Medical College, Cleveland, 1900; aged 57; member of the American Medical Association; died October 6. Dr. Van Epp was a former resident of Medina and Port Clinton. He is survived by his widow, two sons, one daughter, one sister and two brothers.

NEWS NOTES of OHIO

Canton—Dr. H. C. Schmuck, formerly resident physician at Mercy Hospital, Canton, is in New York City taking post-graduate work in general surgery and orthopedics. Upon his return he will open offices here for general practice.

Cleveland—Dr. James A. Doull, professor of hygiene and public health, and Dr. G. E. Harmon, associate professor of hygiene and vital statistics, School of Medicine, Western Reserve University, were on the program at the annual meeting of the American Public Health Association, held in Washington, D. C., October 24 to 27.

Cleveland—Dr. Howard T. Karsner, professor and director of the Institute of Pathology, Western Reserve University, has been elected the United States' member of the Comité Directeur of the International Society for Geographic Pathology.

Mansfield—Offices have been opened here by Dr. D. A. Weir, formerly of Alliance.

Massillon—Dr. O. W. Show is the new president of the Massillon Kiwanis Club.

Springfield—Dr. N. L. Burrell, member of the Board of City Hospital Building Commissioners which supervised the construction of Springfield's new hospital, was tendered an appreciation dinner recently by members of the local medical profession. Following the dinner, Dr. Burrell was presented a wrist watch and was eulogized by several of his hosts.

Columbus—Dr. Sterling B. Taylor was elected third vice president of the American Association of Railway Surgeons at the recent annual meeting of that organization in Chicago.

New Philadelphia—Miss Lillian Shanley, 29, daughter of Dr. E. B. Shanley, Councilor of the Seventh District, Ohio State Medical Association, died November 1 at the home of her father of chronic myocarditis. Miss Shanley, a graduate of Ohio Wesleyan University, had been a teacher in the New Philadelphia schools for the past three years and at the time of her death was teacher of American history in the Welty Junior High School. She was a member of the local College Club, the Church of Christ and chairman of the young women's division of the Tuscarawas County Young Democratic Club. Besides her father, Miss Shanley leaves two brothers, Mendel, of Pittsburgh, and Richard, of Philadelphia. Her mother died in 1923.

Greenville—Dr. W. C. Briedenbach, Dayton; Dr. L. E. Harvey, Lima, and Dr. F. C. Anderson, Mt. Vernon, were guest speakers at a recent meeting of the Greenville Kiwanis Club. All spoke on tuberculosis and the care of tubercular patients.

Zanesville—Dr. M. A. Loebell has been elected president of the local Kiwanis Club.

Peebles—Dr. Robert Ellison, son of Dr. and Mrs. S. J. Ellison, who recently completed his internship in New York City, has opened offices here.

Cincinnati—"Present Trends in Medicine" was the subject discussed by Dr. Julian E. Benjamin at a luncheon meeting of the Lions' Club.

Cleveland—The 31st Hanna Lecture was delivered in the Institute of Pathology, Western Reserve University, by Dr. W. Baensch, professor of radiology, University of Leipsig, who discussed "The Radiological Relief of Gastric Mucosa".

Xenia—Second of a series of vocational guidance classes for the boys and girls of Xenia was held recently under the auspices of the local Kiwanis Club, the subject being "The Profession of Medicine". Speakers were Dr. B. R. McClellan, Dr. Paul D. Espey, and Dr. A. C. Messenger.

Painesville—"The Care and Feeding of Children" was the subject of an address made by Dr. R. H. Spence before the Nursery Parent-Teacher Club.

Painesville—Dr. James G. Powell, formerly of Cleveland, has opened offices here.

Upper Sandusky—Dr. R. L. Garster, formerly

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an intern at the Youngstown City Hospital, has located here.

Coshocton—New president of the Coshocton Kiwanis Club is Dr. James G. Smailes, former president of the Coshocton County Medical Society.

Barberton—Dr. Frank M. Warner and Dr. Stephen Turney have sailed for Europe where they will take post-graduate work at Vienna and Budapest.

Lancaster—Dr. J. J. Hoodlet, formerly of Nelsonville and Haydenville, has opened offices here.

Miamisburg—Dr. Walter M. Simpson, Dayton, addressed the local Lions' Club recently.

Elyria—Dr. W. E. Hart escaped uninjured and his son received a dislocated shoulder when their automobile was hit by a train near Sullivan.

Wilmington—Announcement has been made of the marriage of Miss Ruby Giske, Hollywood, California, and Dr. Dalton Peele, this city.

Cleveland—Dr. E. H. Adler is taking post-graduate work in endocrine diseases at New York City.

Cleveland—Dr. R. E. Barney is convalescing from an operation for appendicitis.

Cleveland—Dr. C. H. York has returned from a years' study abroad, most of the time having been spent at the Children's Clinic at Leipzig.

Youngstown—Dr. Joseph Tuta is taking post-graduate work in Chicago.

Toledo—Dr. Wendell W. Green has returned after a year's post-graduate work in New York in proctology.

Toledo—Dr. I. Krishna is taking post-graduate work in tuberculosis at New York City.

Toledo—Dr. L. R. Carr has returned from work in orthopedics at London, Berlin and Vienna.

Piqua—Dr. Louis P. Alff, only living member of the Piqua Medical Society predecessor to the Miami County Medical Society, was honored recently with a dinner given by the staff of the Piqua Memorial Hospital. Dr. Alff will be 81 years of age next December. He has practiced in Piqua since 1879.

Ashland—Dr. Henry R. O'Brien, Lorain County health commissioner, recently addressed the local Rotary Club at a "Public Health Day" celebration.

HOSPITAL NOTES

—New appointments to the visiting and consulting staffs of the Bedford Hospital are as follows: Visiting staff, Dr. G. D. Cameron, Sr., Dr. G. D. Cameron, Jr., Dr. V. C. Kenney, Dr. R. M. McCullough and Dr. E. P. Friedl; consulting staff, Dr. James N. Wychgel, Dr. J. R. Thompson, Dr. Walter G. Stern and Dr. R. W. Finley.

—Miss Camille Sonnefeld has resigned as superintendent of the Geneva Community Hospital.

—The new Barnesville General Hospital was opened on October 25.

—Warren City Hospital observed its 25th anniversary recently with open house and a program at the nurses' home.

—Mercy Hospital, Hamilton, recently celebrated its 40th birthday.

—Miss Mary Jackson has resigned as superintendent of the Lodi Hospital and has been succeeded by Miss Theresa M. Hayes, formerly of Amherst.

—Springfield's new $1,800,000 City Hospital was dedicated September 25 with appropriate ceremonies. The principal address was made by Dr. J. H. J. Upham, dean of the College of Medicine, Ohio State University.

—Miss Margaret Wollbold has been named acting superintendent of the Twins City Hospital, Uhrichsville, succeeding Miss Rhoda Barker, resigned.

—The Greenfield Hospital, closed two years ago because of financial difficulties, has been reopened and will be operated on funds raised by various civic organizations of Greenfield.

—The nurse training school of the Piqua Memorial Hospital has been closed and the nine students transferred to the training school of the Miami Valley Hospital, Dayton.

—Dr. H. T. Sutton was elected president; Dr. C. H. Roach, vice president, and Dr. R. S. Martin, secretary, of the staff of Good Samaritan Hospital, Zanesville.

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PUBLIC HEALTH NOTES

—Dr. Richard H. Wallace has been appointed health commissioner of Bexley, succeeding Dr. Hugh C. Thompson who resigned to take post-graduate work at Columbia University Medical School.

—Dr. W. C. Marshall has been appointed health commissioner of Greene County, succeeding Dr. R. H. Grube, resigned.

—Dr. A. B. Lippert, formerly head of the Bureau of Child Hygiene, State Department of Health, has been appointed health commissioner of Shelby County.

—The following article, based on the State Department of Health's carbon monoxide annual report for the year ending June 30, 1932, was published in a recent issue of the *Ohio Health News*:

The carbon monoxide annual report to June 30, 1932, has just been compiled and is made public by the State Department of Health. It shows that 70 persons took a risk with this dangerous gas in domestic appliances and 82 persons in connection with automobiles. This is the first year that reports for automobiles have led.

TABLE I. CO Mishaps from Domestic Heating Appliances, for Each Year Ending June 30.

	1928	1929	1930	1931	1932
Non-fatal	98	132	71	94	45
Fatal	38	36	52	29	25
Totals	136	168	123	123	70

The accompanying Table I shows for domestic appliances a marked falling off of reported cases, and less so for fatal cases, as the five-year period has proceeded. As reported before, the arch fiends have been "room heater—bedroom—no flue" and "water heater—bathroom—no flue". Occasionally it was a kitchen gas-range or a hot-plate, and in a few instances a mishap occurred from a leak of raw gas, but almost invariably it was defective burners—i. e., not enough air in the air-gas mixture.

Three deaths occurred among tramps living in a shanty and using a common stove, and two non-fatal cases occurred from the use of charcoal in a bucket for heating purposes. This last type of mishap is a reminder that Benjamin Franklin was so impressed with the ghastly deaths from charcoal braziers in his day that he invented the stove or furnace and gave the patent rights free to the world in the early 1750's.

At least a half dozen cases were suicidal, while 17 were not officially checked, but only two of these were fatal.

Persons of all ages were involved in these mishaps. In one instance, a young mother and her infant baby at Athens, Ohio, were fatally poisoned while stopping over-night enroute to the southern part of the state, and by a well-known, high-grade room heater which has seldom appeared in mishaps before.

A few persons conceived the idea, which is false, that they could get more heat out of the gas flame by setting something on top of it such as a flat iron, a bread toaster, etc.,—but they got CO poisoning. Many persons would not have been gassed if they had cleaned flue pipe and chimneys. A dead owl was found in a stove pipe of a kitchen gas range. Many went to bed with the gas burning, forgetting that in the dead of the night, when the gas pressure almost invariably increases (because of lessened general use), the flame will become very high and produce monoxide. Too often traveling men or students went to sleep in a bedroom with a gas stove lighted.

TABLE II. CO Mishaps from Motor Exhaust Fumes, for Each Year Ending June 30.

	1929	1930	1931	1932
Non-fatal	35	49	57	39
Fatal	28	35	41	43
Totals	63	84	98	82

There is also a formidable story of cases due to motor exhaust fumes—total for the year being 82, of which number 43 were fatal. "Motor run-

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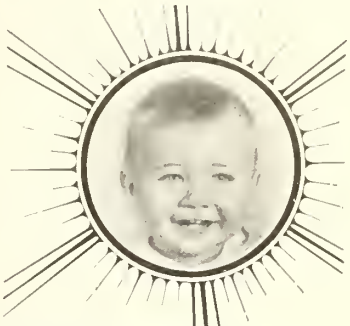
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ning in closed garage" is the big banner in this list. There were at least 42 cases of this nature, and nearly all of them occurred in connection with the garage at the residence. Coroners declared that some were suicidal, but these were comparatively few. One fatal case occurred in a closed car which was attempting to drive through a stream. Several occurred where persons were keeping the motor running for heat. One man narrowly escaped while placing his grips in the rear compartment of his auto. One man combined auto gas with shooting as a lethal exit and succeeded, while another failed with a combination of motor gas and anesthetic. The garage under the house was also inculpated, and several persons had narrow escapes. Three persons had narrow escapes while seated in the cab of a large truck. There were some other miscellaneous cases in connection with fires, hot bearings producing monoxide gas from scorched oil and, of course, a number of industrial cases, but these are not included in the foregoing figures.

It was 10 years ago that the State Department of Health issued its *Carbon Monoxide Warning*, among the first instances of the use of the radio in state public health work in the United States (Nov., 1922), which had been begun by this Department in March of that year. Shortly after, the Ohio Public Health Council declared for "(1) effective venting of every gas-fired room heater and * * * * water-heater to the exterior of the building; (2) the removal of all gas-fired water heaters from bathrooms and kitchens and similar quarters; (3) the discontinuance of the use of all gas-fired domestic appliances for heating purposes unless effectively flued to the outside air; and (4) that teachers and textbooks * * * * emphasize the correct use of all gas-fired appliances for the protection of health, safety and life."

—Dr. H. H. Pansing, health commissioner of Montgomery County, was a recent speaker before the Brookville Rotary Club.

—Dr. C. R. Colburn has been reappointed part-time health commissioner of Clermont County.

—Dr. W. S. Weiss has been reappointed health commissioner of Ashtabula County.

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